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ABSTRACT

These five symposium papers address the gap between behavioral and psychoanalytic theories. "Teaching the Integration of Different Models to Therapists-in-Training," by Richard P. Halgin, suggests that students should concentrate on a broad-based education, using the best of several approaches to fit individual client needs, rather than choosing an established school of psychotherapy. "The Transition from Behavioral to Exploratory Psychotherapy," by Bruce Kerr, presents the issue of clinical flexibility as an approach to the complexity of human behavior. Case studies are used to illustrate the need for mastery of different clinical models. "The Integration of Behavioral and Psychodynamic Techniques in the Group Treatment of Sex Dysfunction," by Robert Muller, presents an open-ended, client-based, interpersonal orientation model. A study showing the effectiveness of this approach is included. "Integration of Behavioral and Analytic Modes: A First Year Student's Perspective," by Aimee Grunberger, points out that the notion of rapprochement originated in the form of endless journal debates over the relative merits of one type of therapy over another. Reviews of several studies on comparative therapies are presented. "Learning to Listen: Modifying a Psychoanalytic Psychotherapy," by Linda Kanefield, presents a case study based on the dynamics of the counselor client relationship. Modification of the therapist's neutrality, use of interpretation as a major tool, and analysis of transference are discussed along with the effect of these changes on the therapist's capacity to respond differently to different patients. (JAC)

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INTEGRATING BEHAVIORAL AND PSYCHODYNAMIC THERAPIES: ISSUES IN TRAINING AND TREATMENT

Symposium Papers

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Papers presented at the Annual Convention of the American Psychological Association, Washington, DC, August 23-27, 1982.

TABLE OF CONTENTS

Teaching the Integration of Different Models to Therapists-in-Training

A paper which was presented as part of a symposium entitled Integrating Behavioral and Psychodynamic Therapies: Issues in Training and Treatment at the 90th Annual meeting of the American Psychological Association, Washington, August, 1982.

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2.10.1 Behavioral Psychology/Treatment Methods
2.10.2 Dynamic Psychotherapy/Treatment Methods
2.12 Training

Teaching the Integration of Different Models to Therapists-in-Training

The major purpose of this symposium, and particularly this paper is for me to turn myself in. To admit publicly my participation in a plot to keep psychotherapy from being effective, both in terms of cost and therapeutic impact. This process in which I have had a limited but nevertheless culpable amount of participation has gone on for many years, and has consisted of the following: psychotherapy teachers telling psychotherapy students that there are established schools of psychotherapy, and that to be a real therapist one must belong to one of these schools. As a member of the school, one learns and subsequently espouses a particular way of doing therapy. One learns that the presenting problem of the client must be understood and treated within the guidelines of the school.

If one looks at any therapy training curriculum, it will immediately become evident that therapy for the most part is taught according to schools. In our own curriculum at the University of Massachusetts the two primary therapy courses are the behavioral and the psychodynamic core courses. The treatment teams in our department's Psychological Services Center are also theoretically identified; for example for the past five years I have taught a psychodynamic psychotherapy team. Others have taught behavioral teams and family teams. However, I know for a fact that at times my team has done work quite definitely behavioral in nature, and that at times the behavioral teams have done work more commonly associated with a dynamic approach. No one considers this phenomenon

particularly bizarre, though the first year students typically experience a sense of surprise. It has been my experience that students entering graduate training often have rigid notions about psychotherapy, and often feel compelled to identify with one of the therapy schools even during the application process to graduate school. Very likely this stems from undergraduate education which fosters very simplistic ideas about psychopathology and psychotherapy. I was struck by this fact three years ago while teaching an undergraduate abnormal psychology course. I used a very fine and very popular textbook which was well received by my students; however, the text was structured in a way which initially seemed quite good but now stikes me as problematic. The authors viewed each diagnostic category from the vantage point of the major perspectives, and provided the treatment intervention which corresponded to each perspective. At first it struck me as a fair and comprehensive approach, but gradually I noticed the students identifying themselves with one of the perspectives and defending the corresponding treatment approach regardless of the presenting treatment problem under consideration.

The following year I was a member of the admissions committee for our doctoral program in clinical psychology; in this position I read several hundred personal statements and found in many applicants' statements the same kind of professed adherence to particular schools. In fact, I would venture a guess that the individuals who had articulated such adherence were more successful in gaining admission than those who saw themselves as more eclectic or undecided. I think that the presumption of committee members was that the adherence to a particular perspective

was very likely the result of an informed process of choice. I now feel that it was probably a much more haphazard matching, resulting in most cases from some coincidental academic experience, such as a single course or a particular relationship with a faculty person.

During the same year that I sat on the admissions committee, one particular case was referred to my psychodynamic psychotherapy team for which a behavioral approach seemed clearly indicated. The case involved a young woman who requested help with a public speaking phobia. At that time the client was enrolled in a course which required an end-of-the semester oral report, and her sole purpose in seeking therapy was to prepare herself for this event. The therapist to whom the case was assigned was quite knowledgable about behavioral therapy approaches and an appropriate behavioral intervention was undertaken. The case was a striking success, and I learned quite a bit from my supervisee, both about behavioral intervention and the need for flexibility of approach. It should be noted that the treatment consisted of more than relaxation exercises and practice sessions; attention was given to other factors which seemed relevant to the treatment. These included exploration with the client of other variables in her life both then and in the past which might serve to accentuate her phobic response. Also, the therapeutic relationship was addressed in a way which seemed appropriate to the treatment. As the treatment progressed, there was a concomitant occurrence within the structure of the team which caught me off-guard. To my surprise, a split had developed between the members of the team with one group feeling quite comfortable with the behavioral treatment undertaken for the phobic woman, and the other group

quite openly opposed to such directive intervention. Within my own mind, this split accentuated my own crisis of theoretical faith. I began to fear that I was a perpetrator of ideological, therapeutic, and didactic heresy, and that at any moment I would be reported to the authorities (people such as Otto Kernberg, or even worse, Robert Langs!). I feared that my three years of clinical training at Cornell Medical Center would be declared invalid and that I would be forced to join the American Association of Behavior Therapists.

As I struggled through this period of crisis, a higher force sent me a message of redemption. During a casual stroll through the University book store I came across a book which not only told me it was permissible to bridge the psychoanalytic-behavioral gap, but explained how and why such a bridge should be built. Paul Wachtel's book, Psychoanalysis and Behavior Therapy: Toward An Integration (1977) provided an intelligent and perceptive look at the complementary aspects of these two treatment approaches. I was relieved to see in print what had seemed such a sensible strategy to me, and what I felt had been practiced by so many therapists for a long time but rarely articulated. Reading Wachtel's book helped clarify the issue in my own mind and resolve the crisis on the team. Since that time I have more carefully explained the nature of my team's ideology, and have begun each year with an elucidation of the premise that the team's work would be psychodynamically based but not in such a rigid way as to obscure the appropriate treatment needs of each client.

Around the same time as the above mentioned incidents I was

beginning to do some work in the treatment of sexual dysfunctions. This was one area in which bridges were starting to be built between behavioral and dynamic approaches. In her first text, The New Sex Therapy, Helen Singer Kaplan proposed an integrated application of behavioral and psychodynamic approaches in treating sexual dysfunction. She formulated a model of sex therapy which "when practiced within a psychodynamically oriented multicausal framework, does not rely on sexual tasks alone to resolve conflicts." (p. 153). In Kaplan's second text (1979), she even more emphatically recommended that sex therapy as an isolated behavioral intervention be abandoned. She described a treatment modality which purposefully integrates prescribed sexual experiences with psychotherapeutic exploration of intrapsychic and interactional defenses and resistances. The behavioral prescriptions "are designed to relieve performance anxieties and obsessive self-observations, and desensitize mild sexual tensions. The psychotherapeutic work which contains elements of support of sexual pleasure, confrontations with resistance, exploration of unconscious conflicts, and marital difficulties is aimed at clarifying and resolving those deeper causes which have shaped the sexual problem" (p. 146).

Perhaps the greatest contribution of Helen Singer Kaplan in her formulation of a new sex therapy was the granting of permission for therapists to be pragmatically eclectic. Her model not only permitted, but strongly encouraged behavioral and psychodynamic therapists to incorporate each other's therapeutic strategies into a very meaningful and sensible treatment program. One specific case which I supervised of a

woman requesting treatment for inorgasmia stands out in my mind. The success of treatment was as much attributable to the interpersonal and historical exploration done by the therapist, as it was to the behavioral exercises which were assigned.

Because I had been doing and teaching some sex therapy, I found myself being labelled a "sex therapist," a term which I objected to. My objection stemmed from my concern that the mental health profession was beginning to foster mental health specialties analogous to the specialities within the field of medicine. It seemed that in recent years mental health practitioners were becoming increasingly specialized; and though there is much to be said for a practitioner who knows a specific field very well and is able to capably apply the techniques of the speciality, I feel that a serious problem arises when the practitioner gains his or her special knowledge completely at the expense of acquiring a more broad-based familiarity with various treatment methods. The profession would be better served if intelligent assessment were fostered, such that the good practitioner would be the one familiar with several methods and knowledgeable enough to tailor the treatment to the needs of the client.

What has become apparent to me is the fact that for several years I have been utilizing a variety of clinical techniques, though I have been labelled myself a psychodynamic therapist. Many would call it being eclectic, but that is a term I dislike. Probably the reason I dislike it is due to the fact that it seems to have fallen into disfavor; and probably the reason it has fallen into disfavor is specifically due to the processes I have just mentioned. Namely, the "good therapist" has been the one who is based

in a single school, the faithful adherent to the tenets and techniques of that school. Therapists with multiple concurrent theoretical emphases have been more customarily regarded with suspicion, with the presumption being made that rather than using one technique well, they are using several techniques poorly. So let's dispense with the term eclectic, and in its place I would like to suggest "pragmatic blending." By this I mean that a therapist should have a broad repertoire of skills and techniques, and the ability and willingness to utilize that which seems appropriate for each client. Each therapy will be defined not according to the specifications of a single approach, but by the appropriate blending of various approaches, as dictated by the assessed needs of the client.

I realize that I am not suggesting anything that is radical, not even anything that is particularly novel; for I believe that most of us are pragmatic blenders, though we fail to acknowledge it. This reminds me of the statement made by a patient during a recent intake. This woman had recently been discharged from a well-known psychoanalytically-associated treatment facility. When I asked her about the use of medication at the facility, she responded, "Oh, they don't believe in medication there." She then hesitated for a moment and continued, "But, now as I think of it, for a place that doesn't believe in medication, it's odd that so many of the patients were prescribed meds." My point is that our conception of what we do, and our public proclamations of what we do therapeutically, often differ markedly from the reality of our clinical work. So let's start telling our students the truth about what goes on behind the closed

therapy door. Let's start teaching them that there are so many approaches and no single approach is right for all clients. Even in the treatment of a single case, several therapeutic approaches can be utilized to bring about a successful course of treatment. Admittedly, it is a difficult task to judiciously determine what needs to be done when. The danger is always there that both the therapist and the client will become confused if there seems to be a random application of methods. What I am suggesting is a stylistic blending of approaches which entails carefully considered decisions at the outset of therapy and more subtle determinations during the course of treatment.

Let us take the best of what each approach has to offer and apply it knowledgably and appropriately to the needs of the client.

Kaplan, H. S. The new sex therapy. New York: Branner Mazel, 1974.

Kaplan, H. S. The new sex therapy (Vol. II): Disorders of sexual desire. New York: Brunner Mazel, 1979.

Wachtel, P. Psychoanalysis and behavior therapy: Toward an integration. New York: Basic Books, 1977.

"The Transition from Behavioral to Exploratory Psychotherapy"

A paper which was presented as part of a symposium entitled Integrating Behavioral and Psychodynamic Therapies: Issues in Training and Treatment at the 90th annual meeting of the American Psychological Association, Washington, August, 1982

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2.10.1 Behavioral Psychotherapy/Treatment Methods
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"The Transition from Behavioral to Exploratory Psychotherapy"

Cognitive psychologists tell us that there are two basic ways in which we come to understand, or process, information about the world around us. These are referred to as "top down" and "bottom up" processing. Top down processing refers to the use of knowledge we already have to understand a particular phenomenon. We identify the incoming sensory stimuli based on categories of knowledge we already have, and thus come to understand those stimuli in terms of our prior categories of knowledge. Bottom up processing, on the other hand, refers to the development of knowledge based on the fine-grained, piece by piece examination of the features of the incoming stimulus itself, rather than identification based on our prior knowledge. It is often relied upon when our prior knowledge does not adequately encompass the phenomenon at hand.

Obviously, top down processing is highly efficient; one need not rediscover the wheel each time one sees a wheel. On the other hand, bottom up processing is useful if one has never seen a wheel, and is confronted with one for the first time. In any situation, our processing of information is always a combination of these two factors, but across situations, the relative balance of our reliance on the two changes, depending on the applicability of our prior knowledge and the novelty of the presented phenomenon.

What, you may ask, has all this to do with the clinical issues at hand? Jay Haley (1976) has said that there are two basic approaches to clinical work: a method-oriented approach and a problem-oriented approach. A method-oriented approach to clinical work is one in which the category of formulation and treatment techniques applied to any given case are determined,

a priori, by the therapist's committment to a certain clinical theory. Thus, even before the individual client is seen, the analyst knows that if he or she accepts the client for treatment, some form of psychodynamic formulation and treatment will be used, while the behaviorist knows that a behavioral formulation and treatment will be developed. A problem-oriented approach, on the other hand, would be one in which the choice of modality of formulation and treatment is made based on, and to seemingly best fit, the needs of the specific case as they unfold, rather than those of a prior theoretical posture. The method-oriented approach to clinical work is very "top down", to use the cognitive psychologists' term, in that it is guided by what a therapist already knows or believes, on a theoretical level about psychopathology and psychotherapy. A problem-oriented approach, on the other hand, is more "bottom up" in that it selects its formulation and treatment approach based on the pragmatics of the specific case, rather than the committment to a single, pre-existing theory.

Clinicians who have been trained in, and who profess, the more or less exclusive use of a single model of therapy are more prone to be top down in their work. They tend to fit the client's presentation into the theoretical and technical model they are committed to. A bottom up clinical approach, on the other hand, attempts to select a theoretical and technical model which best fits the pragmatics of the specific case. This latter approach is obviously facilitated by the mastery of a number of different therapeutic modalities such that the treatment devised in any given case can consist of choices not only between details of techniques within a single model, but the adoption of various models per se.

In its simplest form, the issue here is basically one of clinical flexibility, and of the way in which one views the complexity of human behavior. If human behavior is seen as being sensical on a number of different levels of analysis, which are not completely reducible one to the next, then the mastery of multiple clinical models which differentially emphasize these levels is appropriate. If, on the other hand, human behavior is believed to be explicable on the basis of a single level of analysis, with all other levels being secondary or reducible to this level, then mastery of a single approach which emphasizes that level is likely to be thought sufficient. Certainly, the position of this paper, and of this symposium, is that behavior is complex and sensical on a number of different, and not necessarily reducible levels, and thus the mastery of different clinical models is appropriate. The cases presented today examine the utility of a psychodynamic, behavioral ambidexterity, but group, family system and community models, to name but a few, could fit here as well.

By way of illustrating the utility of the mastery of different models of clinical work, as well as showing some of the unique advantages and problems of this type of effort, I would like to summarize for you certain aspects of a case in point.

The client was a 32 year old white female who presented with a 14 year history of bulimia which had become radically worse over the past two years. She was married with no children, and currently unemployed although she had a record of strong achievement in both school and work situations. The referral was made by her physician who was concerned over the potentially lethal physical complications of her two to three times daily pattern of

binging and self-induced vomiting. These included kidney malfunctioning, a torn hernia, and electrolyte imbalances. At the initial session, the client presented herself as a well-groomed, very thin woman who told her story in an embarassed, and yet somewhat dramatic manner, denied any other problems in her life, and was at a loss to understand or explain her bizarre eating pattern.

The client had a history of 2 prior insight-oriented therapies with experienced and competent doctoral level therapists. Neither of these therapies had resulted in a significant decrease in the symptom pattern, and the client was quite resistant to engage in insight-oriented inquiry about her problem. Here then was an initial choice point in the delineation of a therapeutic approach to this client: the client was presenting with grave physical problems which required immediate attention, and she had a history of not responding to insight-oriented treatment. Haily comments that the hallmark of the method-oriented therapist is his or her persistance with the use of a method with a client, in the face of the demonstrated treatment failure of that method with that client. The problem-oriented therapist is one who, presented with convincing evidence of the inefficacy of a specific approach with a specific client, changes his or her approach. Given the inefficacy of the client's past therapies in reducing the symptom pattern, and the urgent need to do so, a problem-oriented approach suggested the consideration of alternative treatment strategies, and in this case, an initially behavioral approach aimed directly at symptom control appeared to be the best alternative.

The client was placed on a low calorie diet. This was done to regularize her eating pattern, disrupt her current pattern of starving herself in the

day and binging at night, and also to help her feel in control of her eating. By using a low calorie diet, the client could be assured that her weight would not balloon, and yet also be assured of proper nourishment. The client was also asked to keep a diary of everything she ate, binges and regular meals included, the circumstances of her eating including time, place, preceding and following events, and presence or absence of others, and the frequency of her purging. From this diary a number of important precipitating events involving temporal and situational cues were identified and gradually eliminated via environmental and cognitive restricting, and over a period of 3 to 4 months, the frequency of her binging was reduced from a rate of 2-3 times per day to 2-3 times per week. At this point, examination of the remaining binges, which proved quite resistant to the techniques used thus far, indicated that the vast majority of them occurred in relationship to some incident with a significant other, usually the client's husband, mother, or mother-in-law, in which an observer might have expected that the client would feel some aggressive affect such as anger, or engage in some self-assertion, and yet the client did not. Instead, she would act in self blaming and self sacrificing ways, and also eat. When this pattern was pointed out to the client, without any interpretation of its meaning, the client agreed that it was curious and agreed to talk about her marital and family relationships. Thus, the symptom focused behavioral work reduced the symptom pattern enough that the overlay of more recently acquired trivial precipitants such as times and places which had become attached to the eating pattern were stripped away, and the core of the more primary and resistant inter and intrapersonal consequences of the symptoms were clearly highlighted such that the client

could be presented with them and induced to talk about them.

The initial successes of the behavioral methods had the result of deepening the therapy relationship, raising the client's hopes, and pulling for her to trust and depend upon the therapist. Insofar as the client's increasing dependence on, and desire to please and comply with, the therapist began to recapitulate her relational patterns with other significant figures in her development, the behavioral work had significant effects on the development of the transference within the therapy. While the client remained resistant to directly addressing these issues with the therapist, she was able to address the issues as they occurred with other transference figures in her life, specifically her husband and mother-in-law. Of course, there was also a price to be paid for beginning the therapy in this manner. Essentially, the behavioral techniques trapped the client between her transferential urges to be the good client, as she had tried to be the "perfect" daughter and wife, and her urges to continue to use her eating pattern to regulate her anxiety and her interpersonal relationships. In an attempt to "earn" the therapist's affection and caring, the client would perform the difficult task of modifying her eating, but of course this begged the question, which the client was able to address openly later within therapy, of who she was getting better for, and indeed, who she had been living for and trying to please her entire life. At the point at which the client was able to openly and angrily accuse the therapist of forcing her to change, the therapist was able to point out to the client that her presence in treatment was voluntary, and her anger over feeling forced to conform her self to the wishes of others to insure their affection

and attention was a long standing problem which transcended the therapy and was in fact a theme in her life since earliest childhood. It was at this point that the client consciously began to consider her symptom pattern in terms of her entire development.

The remainder of this two-year therapy was spent doing insight-oriented therapy with this client. Typically, the client was able to work on conflicts as they appeared with her family before she was able to confront them in the session with the therapist, but ultimately she was able to do both, and to act on her insight to change her life outside of the therapy room. When the therapy terminated, the client was symptom free, had made significant gains in her ability to integrate objects, and was able to be more self assertive and self expressive in her interpersonal relationships.

Obviously, there are many aspects of this therapy which cannot be discussed in a brief presentation such as this, but the material presented does, I think, highlight the major point to be made here: both behavioral and dynamic work were necessary to access and aid this client, and neither type of work, by itself, would likely have been sufficient. The behavioral gains would not have been maintained if the client's characterological need to comply in order to defend herself against the fear and depression of abandonment had not been addressed. The dynamic level of work, on the other hand, would likely never have been reached with this client without the early relational benefits derived from the initial symptom reduction which was made possible by the use of behavioral techniques.

The crucial variable which allows for the successful combination of these elements in a therapy is the ability to understand the effects of

working with one model in terms of the other models used in the therapy. Unfortunately, often the effect of considering one model within the terms of another is the conclusion that the models are incompatible and that attempts to blend them are at best ill considered, and perhaps even somehow dangerous. This conclusion is especially likely when the examination is carried out on a theoretical basis. Theoretically, behavioral and dynamic theories of human behavior are quite distinct and in places clearly contradictory. On a pragmatic level, however, experienced clinicians of differing orientations often show great overlap in what they actually do with a client, even though they might explain the same actions differently. Obviously, there is a certain amount of slippage between the levels of theory and practice in those areas where clinicians of different minds can agree on what to do, although not agree on why they are doing it. The important requirement for the use of a blended thearpy is the ability to understand one's practice with a client from different points of view.

How can we train clincians to be able to do this? It is my sense that the ability to do this is often gained or lost early in one's training, and depends on the meta-attitude one is, often implicitly, taught to take in regards to theory. If one is taught to approach theory as essentially a heuristic device, then differences in theory, even contradictions between theories, become matters of choice as to the best or most adequate, manner of understanding a particular phenomenon, or case, for a particular purpose, which in therapy is usually some form of effective change. If, on the other hand, one is taught to approach theory as truth, as a veridical model of

how things really work, then contradictions in theory become contradictions in fundamental theology, which are notoriously difficult to resolve. The issue is one of reification because reification is antithetical to the type of flexibility a clinician needs if he or she is to be able to integrate different clinical models.

I do not think that this integration can be taught directly; clinical models are best taught in a "pure" form. In this way, the contradictions between models have the potential to become the thesis and antithesis of a dialectical process. The over arching element which allows the dialectical potential to be realized, and which allows the thesis and antithesis to form the dialectical synthesis is the ability of the clinician to think independently and critically about each theory, and to avoid the type of reification which turns the dialectical tension between thesis and antithesis into an unresolvable, unsynthesyzable contradiction. If this requirement is met, then each clinician will have the opportunity of formulating a synthesis, but this will be a process for each individual therapist to struggle with. The synthesis cannot be pre-digested and taught directly, it must oe the outcome of each person's efforts with the dialectic. Otherwise, what one is left with is a random ecclecticism rather than a personally meaningful synthesis.

In sum, then, the ability of a therapist to select from among different treatment models the aspects which, conceptually or pragmatically best fits the unique requirements of a case lends a flexibility to the therapist's work which can be most useful. The ability of a therapist to do this rests

upon the thorough aquisition of the theory and technique of different models and in the development and retention of a critical attitude towards these models such that reification is avoided and contradictions can be tolerated. It is crucial that a therapist be able to understand the use of a technique not only from the point of view of its own model, but in terms of its effects as seen within the other models being used. The critical attitude which allows for the multiple understandings of the effects of technique is the understanding of theories as heuristics rather than absolute truths.

The Integration of Behavioral and Psychodynamic Techniques in the Group Treatment of Sex Dysfunction

A paper which was presented as part of a symposium entitled Integrating Behavioral and Psychodynamic Therapies: Issues in Training and Treatment at the 90th Annual meeting of the American Psychological Association, Washington, August, 1982.

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2.10.1 Behavioral Psychology/Treatment Methods
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"The Integration of Behavioral and Psychodynamic Techniques in the Group Treatment of Sex Dysfunction"

My project involved an attempt to integrate behavioral and psychodynamic strategies in the group treatment of men troubled by premature ejaculation. When I first began looking into the sex therapy literature, I was impressed by reports of high success rates for improving sexual difficulties. I was concerned, however, that the sexual symptom seemed to be isolated from its interpersonal context. It also seemed that more focus needed to be placed on the individual's attitudes and expectations towards sexuality and sex role which may contribute in a significant way to dissatisfaction with sexual relations. I think this is especially true for men.

A man's sexuality has been equated with his very essence, his manhood. Males are socialized to believe that their worth is based on the achievement of certain designated goals both in the workplace and in the bedroom. The medical model has perpetuated this belief: In previous diagnostic manuals an individual who was unable to get an erection was labelled "impotent" and a man who was unable to ejaculate intravaginally was said to suffer from "ejaculatory incompetence". (...it sounds like ejaculatory "nincumpoop".)

Even in today's supposedly liberated society, to speak openly about sexuality and sexual problems, especially for men, is almost unheard of. This inability or unwillingness to share these difficulties with others contributes to a sense of isolation which then leads to increased performance anxiety. There is research which indicates that men often perceive other males to be performing sexually better than themselves. For our sample,

a number of men on the pretreatment questionnaire indicated that while their partners rarely or never were brought to orgasm through intercourse, they estimated that this occurred almost all the time for other men and their partners. Similarly, these same men reported rarely or never achieving simultaneous organsm with their partners, yet they perceived this to be the usual case for other couples. It is clear how this secrecy and isolation surrounding sexuality contributes to distorted expectations.

To a large degree, performance pressure seems to be a self-imposed restriction reflecting the male's unwillingness to relinquish control, to accept and enjoy less structured and more egalitarian sexual relationships (Gross 1978, Polyson 1978). Zilbergeld (1978) lamented that men have accepted unrealistically high standards by which to measure their equipment, performance and satisfaction, thus insuring a perpetual no win situation. It is clear that unless these standards and expectations are addressed during treatment many of these men afterwards will continue to place themselves in "no win situations".

Part of a comprehensive treatment program must help a man to place his "dysfunction" in proper perspective. A treatment program developed by this author served this function in two ways: First, by organizing a group of men to openly share their similar problems which each had previously perceived as his unique, shameful handicap. (One of the initial comments in the very first group was from an individual who announced, "I thought this was going to be a loser's club, but everyone looks pretty normal.") A second goal of the group was to open up for exploration and discussion attitudes concerning sexuality and masculinity which without question

contribute to anxiety around performance during sexual relations and therefore interfere with feelings of satisfaction and sexual fulfillment.

A successful treatment strategy should also include behavioral exercises adapted from the work of James Semans (1956) and proven effective by many sex therapists including Kaplan (1974), Zilbergeld (1975) and Perelman (1980). These procedures would help these men to more accurately perceive bodily sensations premonitory to ejaculation. Increasing the man's awareness of his bodily excitement would allow him to more accurately monitor his level of arousal, thus enabling him to experience the prolonged excitement of the plateau stage of his sexual response cycle.

It has been established that heightened awareness of one's own bodily excitement can improve ejaculatory control. The author, however, felt strongly that exercises must not be isolated from an open and supportive therapeutic context. To help men focus on and observe their physical reactions to a sexual situation, without a concommitant concentration on and exploration of the man's psychological reactions to the situation would be inadequate and incomplete. In fact, the assignment of sexual exercises for developing better ejaculatory control without addressing the man's attitudes and expectations for himself, his partner, and their sexual relations is to reinforce his anxiety that it is only his "sexual skills" which need to be developed or refined in order for him to have more satisfactory sexual relations.

Past efforts at the group treatment of men troubled by premature ejaculation have been primarily leader-centered, quite structured, and behaviorally oriented (Fleming 1980; Zeiss, Christensen, & Levine 1978; Zilbergeld 1975). These treatment strategies have included assertiveness

training, social skills training, the viewing of thought-provoking films, and the discussion of sex-related topics generated by the group leaders. Zilbergeld, the pioneer of this type of group, stated that the basic format of his group was similar to that of a behavioral therapy group..."most of the communication in the group was between group members and one or both of the leaders." In contrast, the intention of this group was to encourage the utilization of other group members for information, feedback, and support, thus promoting group cohesion which has been recognized as an important curative factor in groups (Dickoff & Latkin 1963, Yalom 1970). Also some of these men who previously thought of themselves as "losers" especially in the sexual realm, were helping each other through the sharing of experiences and feelings.

A fundamental difference between the model presented here and previous treatment efforts was the model's open-ended, client-based, interpersonal orientation. Its goals were more broadly scoped. It had been hoped that through interactions with fellow members clients would come to see themselves more as others do. This interpersonally oriented format provided clients with the unique growth-promoting opportunity to discover, express, and accept themselves in intimate relation to others in the group (Berzon, Pious, and Farson, 1963). Defenses and problematic ways of relating which contributed to both sexual and interpersonal difficulties were observed and interpreted in each client's behavior within the group. Attempts were made to work with the clients' concerns about being accepted by partners, performance anxiety, and unrealistic expectations, by exploring these issues in the

"here-and-now" (Yalom, 1970) of the group sessions. For example, one client expended considerable energy in the group taking care of others and was quite reluctant to have the focus on himself. When this observation was shared with him, this client remarked that indeed this was a problematic dynamic in his sexual relations too--he experienced great difficulty focusing on his own sexual sensations and pleasure. While this model and the previous behavioral models both incorporate sexual exercises (Semans, 1956; Zilbergeld, 1975) and the exploration of attitudes towards sexuality and masculinity as components of treatment, because of the differing orientations and goals, the process within the group sessions varied considerably.

Previous group models have stressed the importance of initial therapist self-disclosures for setting a personal tone in the group and for "getting the ball rolling." After much careful throught, it was decided that the therapists could be most helpful to the group members by maintaining the posture of participant-observers, remaining as "objective" as possible in order to best comment on the ongoing process. The sessions were a forum for the members' thoughts and feelings; the therapists' comments reflected observations about the clients and their interactions both outside and within the group sessions. The therapists, in keeping with the interpersonal orientation of this model, participated considerably less often than the leaders in the behavioral groups. For these reasons, there was no self-disclosure from the therapists, revealing their own philosophies, issues, or difficulties with sexualtiy. This, by no means, appeared to inhibit the expression by clients of personal and sensitive material.

By providing men troubled by premature ejaculation with an opportunity to speak openly about their feelings and anxieties about their relationships,

sexuality, sexual problems and male identity, it was expected that certain changes would occur. These men would become more aware of their interpersonal style and its effect on others. It was believed that these clients would be more able to view their fantasies, fears, and difficulties around sexuality as normal, having heard other men express similar thoughts and emotions. It was presumed that positive group experience of sharing personal feelings with other men was likely to result in the increased probability that these men would become more able to use their male companions as important emotional resources. The exploration and re-evaluation of unrealistic expectations men hold for themselves would encourage an increased flexibility within the man's heterosexual sex role, enabling men to feel more comfort and satisfaction with a wider range of sexual activities. It was expected that these attitudinal changes would result in decreased anxiety during sexual relations and thus promote better ejaculatory control. The performance of the assigned behavioral exercises would train the individual to monitor closely his sexual arousal level, a key element in developing the ability to contol ejaculation.

Methodology

Subjects

Six men participated in the group, five ranged in age from 20 to 23, one was 37 years old and the only married individual. At the start of the group, one man was living with a woman but not married, two had ongoing monogamous relationships, one maintained a long-distance relationship, and one was not involved with anyone. Five of the six men who started the group completed the ten-week program.

Procedure

All the clients for this project resided in a northeastern university town and were recruited through advertisements in the campus newspaper which announced a group treatment program for men "troubled by premature ejaculation". After a screening interview, a pretreatment questionnaire examining the client's current sexual practices, attitudes, and satisfaction level was given. Following this, the client was engaged in an information-gathering interview focused primarily on the individual's sexual history and specific information related to the manifestation of the presenting problem. A life history questionnaire was also given to each client.

Following the ten group meetings, the members were seen individually again. Each client completed a posttreatment questionnaire and also participated in an open-ended interview discussing his group experience.

Sessions were one and a half hours long and were once a week. The group met ten times, consecutively except for a vacation break between sessions three and four. There were two therapists, myself and Dr. Halgin. The group sessions were conducted primarily in an open-ended manner with an interpersonal orientation. Topics of discussion developed out of the concerns which the clients brought to the group. The cotherapists functioned mainly as facilitators of the group process, and when indicated, offered interpretations.

While an attempt was made to minimize the amount of structure to the meetings, the integration of the sexual exercises into the group format necessitated some structuring of the sessions. Each group ended

with the assignment of specific behavioral exercises designed to promote better ejaculatory control and more satisfactory sexual relations. Each member received a very specific, type-written instruction sheet. These assignments were based on the work of Bernie Zilbergeld (1978), with an integration of certain techniques developed by Helen Singer Kaplan (1975). All of the members participated in the same exercises during the first 3 weeks of treatment. Starting with the fourth week, those individuals who had participating partners were assigned different exercises than those without participating partners. In the beginning of each session issues or problems raised by the previous week's assignment were addressed. Thus, the discussion of the exercises served as a springboard for the exploration of issues relating to sexuality, sexual interactions, and relationships.

Results and Discussion

Based on the posttreatment questionnaires and interviews and clinical observations from sessions, it was evident that the group impacted significantly upon the lives of its members. While each individual reacted uniquely, there seemed to be certain common effects of the experience for those who completed the group. All spontaneously commented on the reassuring perspective they had gained from talking with other men about very personal issues. Improvement in ejaculatory control was reported by every client; they universally added that they felt comfortable employing the control techniques which they had learned. Their questionnaire responses indicated decreased performance anxiety, an expanded sexual repertoire, and predictions of more non-genital sexuality in the future. The members highlighted the group's essential role in increasing their ability to focus

on and enjoy their own sexual pleasure. These men reported that the group had encouraged them to assert their own interpersonal and sexual needs within their relationships.

The members unanimously proclaimed that the most significant aspect of the experience was the reassuring nature of hearing other men share difficulties and concerns about sexuality and relationships which they previously worried were uniquely their own. The group had indeed become a safe and supportive environment in which members were able to explore and challenge each other's expectations and attitudes concerning masculinity and sexuality. These men were able to gain a more realistic perspective on themselves and their sexuality. One member in the post-group interview commented: "I'd never really talked with a bunch of guys before and I had a lot of misconceptions: like you're really screwed up if you have a problem like this... I'd never heard anyone ever talk about this problem, so I thought I was the only one on campus with this problem". (There are 14,000 males at the University)

The individuals who seemed most positively affected by the group experience appeared to be significantly influenced by comments by other members rather than the therapists. This confirms findings (Berzon, Pious, and Farson, 1963; Yalom, 1970) which have maintained that the main mechanisms of therapeutic effectiveness in group therapy reside in the interaction among its members. One of these individuals frequently struggled for control with the group leaders and displayed insensitivity towards his fellow group members. He was, however, able to be reached successfully by his peers. An increased trust and empathic interest in others became evident

in later group meetings. Similarly, another man, a shy and passive individual, received crucial support and encouragement from members, which enabled him to gradually assert himself more during the sessions and in his relationship with his partner.

It had been expected that this new group format would increase the future likelihood that members would come to view other men as appropriate resources for their emotional concerns and would feel more comfortable engaging in intimate discussions with them. Support for this expectation was seen even before the completion of the group: two members spontaneously reported initiating discussions about sexuality with male friends for the first time ever.

It is essential to remember that while issues of sexuality and relationships were explored within the group, members were expected to be following a very specific exercise program. Assignments instructed members to change their problematic sexual interaction patterns. These homework tasks included guiding members in the exploration of non-genital pleasuring, helping them to shift away from an orgasm-centered interaction, and encouraging them to attempt a variety of positions for intercourse. One particularly insightful and verbal member commented that he and his partner previously had talked "endlessly" about this difficulty without resolution. He related that they both were relieved and grateful to be able to focus their energies on concrete strategies to improve the premature ejaculation problem.

While several members reported that the openness and increased communication about feelings promoted by the group had carried over into their personal relationships, it is likely that these improvements also resulted from the homework assignments which often required communications

between partners during sex. Similarly, it is possible that bolstered by a growing sense of mastery and confidence gained through improvement in sexual performance during the exercises, members felt more able to verbalize their feelings. It is neither possible nor important to determine which component of the group treatment influenced members more. It is clear, however, that the behavioral and interpersonal strategies complemented each other effectively to form a successful intervention.

Afterthoughts and Recommendations.

The membership of this group was drawn from a university community. In anticipation of the instability inherent in late adolescent relationships, the group format was designed to be able to accommodate transitions in relationship status and the consequent heterogeneity within the group. As it turned out, four members of the group underwent changes in relationship status during the course of treatment. Fortunately, this model allowed for flexibility, a progression of exercises was available for both men with and without partners, and the group continued to run quite smoothly. In fact, most members in the postgroup interviews mentioned that hearing people talk about their different situations was a helpful aspect of the group.

This model provided a secure bastion within which to focus on "male issues" around sexuality, work, and relationships and provided an opportunity for these men to experience one another in an interpersonally oriented group psychotherapy setting. There did not exist, however, a forum to speak to or hear from the men's partners nor was there a support system for these women to discuss their feelings about the project and the sacrificies involved. Future models may wish to include a forum to speak

with the partners outside of group sessions both for support to better deal with resistances.

Time constraints occasionally inhibited the group's ability to engage comfortably in extended personal discussions. Extending the length of each session from one and a half to two hours seems indicated. The necessity of monitoring each member's exercise progress and explaining the exercises for the following week, as well as dealing with various relationship crises, often caused the ninety-minute sessions to feel somewhat hectic. Two-hour sessions would alleviate some of this pressure.

It is heartily recommended that groups consist of six or seven members. Any larger number would likely dilute the experience for those involved, and any fewer would not leave an appropriate margin of safety in case of drop-outs.

It was the philosophy of the leaders to let the members of the group be the primary sources of support, feedback, and confrontation to each other. While support and feedback of a neutral type were given easily, members appeared reluctant especially in initial sessions, to challenge one another. It is likely that this model can tolerate therapists taking a slightly more active role in modelling an empathic style of confrontation with its members without endangering its principles and philosophical orientation.

While several recommendations for changes in format have been proposed for futher investigation, it is firmly believed that the model presented in this paper offers exciting potential for the effective and cost-efficient treatment of premature ejaculation, as well as other sexual dysfunctions.

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"Integration of Behavioral and Analytic Modes:

A First Year Student's Perspective"

A paper which was presented as part of a symposium entitled Integration of Behavioral and Analytic Modes: A First Year Student's Perspective at the 90th annual meeting of the American Psychological Association, Washington, August, 1982.

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2.10.1 Behavioral Psychology/Treatment Methods
2.10.2 Dynamic Psychotherapy/Treatment Methods
2.12 Training

"Integration of Behavioral and Analytic Modes:

A First Year Student's Perspective"

The impetus for this paper comes from a variety of sources over a period of time which extends back several years, and includes several different clinical and research contexts. My initial contact with psychology was an intensive dive into Jungian psychology, mostly as an adjunct to the typical spate of Sixties interest in mysticism and Eastern religion. Of course, all intellectual types have on hand some Freudian rhetoric and sketchy inklings of the meanings of oral stage, phallic symbol, and dream interpretation. So, without explicitly articulating it, my bias was already that of a dormant analyst. Then, psychology as psychotherapy, as opposed to psychology as philosophy (prescriptive v.s. descriptive?) became primary when I was hired in my first clinical position. This happened to be in a very behavioral lab and the client population happened to be chronic recidivists. So, I vehemently subscribed to that orientation for awhile, completely rejecting and ridiculing my previous stance. Towards the end of my tenure there, many of the issues of theoretical and practical integration began to interest me.

More recently, I was asked to consult on a case at the Psychological Services Center at UMass; instead of overlaying a patina of behavior modification over the psychodynamic foundation, I tried to get a sense of a unified approach. These efforts will be discussed later, as well. Finally, a recent assignment instructed that I choose several disorders and indicate which orientations could supply the most effective treatments for each. This ran counter to my thinking and prompted this paper.

The notion of rapproachement originated in the form of endless journal debates as to the relative merits of one type of therapy over another, sometimes in the form of bona fide treatment outcome studies employing a vast range of dependent variables, but often simply in a virulent exchange of name-calling. There was also divisiveness in the mode of total disregard of conflicting viewpoints. Paul Wachtel, in his introduction, writes, "Behavior therapy... is a major new trend that has developed largely in opposition to psychoanalysis, and the mutual distruct between proponents of the two points of view is considerable. Psychoanalysts and behavior therapists seem to agree on scarcely anything except the joint conviction that they have little to say to each other and that the two points of view are fundamentally incompatible."[1]

The treatment outcome literature is largely composed of one school, usually behavioral, pitting one of its subgroups against another: behavioral against cognitive-behavioral, or relaxation against biofeedback. This makes sense, since the very notion that it is possible to measure and report treatment outcome variables is itself a behavioral invention. The major interest of the treatment outcome literature lies in what is not reported, in what fails to be accomplished, and what is left univestigated.

The following list of these omissions is germaine to this subject in that the unreported variables in the behavioral literature may just be the areas in which things distinctly unbehavioral are transpiring. For example, a Methods section includes the number of therapists involved, their gender, and maybe their level of experience and theoretical orientation. But who can tell what they actually do in the course of treatment? A behavior

therapist may be as emotionally supportive as a Rogerian, as interpretive as an analyst, or as relationship-focused as a Sullivanian. All we are told is that the structured protocol was delivered, not how it was delivered. The obvious interest here is in the so-called nonspecifics of therapy, which could be operationalized in a behavioral mode and analyzed, but are rarely the targeted behaviors. This is one direct result of the development of behaviorism as a reaction to traditional approaches. If the therapist-client interaction was deemed important by the adversaries, then the other side will pay no attention to it.

Not all of the burden can be placed upon any school. Rather, it is academic psychology as a whole, with its emphasis on the necessity that psychology act like a science, that has stimulated several unhelpful developments. The paucity of information given in a typical journal article is largely the result of the strictures of the APA format itself. The Methods sections must include a great deal of information, packed densely and stated tersely. This leaves absolutely no leeway for the vagaries of the therapeutic process, or its discussion.

Second, the rationale for the choice of targeted behaviors is never given. Some observable symptom is supposed to change, then a procedure is administered. Often, the choice is one demanded by in-house research priorities and has little to do with the optimum treatment. Or, as Donald Meichenbaum pointed out at the 1981 meeting of the Association for the Advancement of Behavior Therapy, "We are selective in admitting evidence which will validate our a priori beliefs." Again, we can look to the larger institution for perpetuation of what is essentially an anti-scientific mindset. The implicit laws of tenure and professional advancement demand that

a great deal of one's personal output as a researcher be of the so-called "quick-and-dirty" variety. It is far easier to remain a specialist in one minute subarea of psychology, and to consequently construct studies which will validate the viewpoints arising from this area. If researchers can develop tunnel vision which does not allow for images from other sub-areas to develop, how can we expect psychologists to let in illumination from other orientations?

Lest it appear that only the behavioral research journals are behind the theoretical xenophobia plaguing the field today, the analysts should be given equal time. They have actually been very clever about avoiding the treatment-outcome business altogether by invalidating the premise behind it. Wachtel explains: "In psychodynamic therapies, the assessment of the patient's personality and problems in living and the treatment of those problems are hardly distinguishable. To many dynamic therapists the joint effort by patient and therapist to articulate the patient's way of living his life, and to understand how it developed and why it causes problems, is the core of the therapeutic process. In a sense, the effort to understand is the therapy?"[2]

The agreement among the analysts that the therapy alliance is fragile and nearly numinous in character allows for journal articles composed of verbatim transcripts of sessions, and other mysterious and unquantifiable data, such as Rorschach results. Such a hermetically-sealed process not only does not allow the scrutiny of outsiders, but demands an interpreter from the inside. Before the outcome of therapy can be evaluated in a manner acceptable to both parties, the analysts must find some objective, or at least identifiable and measurable variables to examine. On the other hand,

the behavioral psychologists will have to target more global items, if rapprochement is to ever occur.

Before leaving this delineation of obstacles to integration, a few more general barbs ought to be hurled. It is the nature of institutions that they resist change and help perpetuate stasis; the institutions of psychology adhere persistently to this law. In the realm of clinical training, the hardening of the theoretical lines begins at the time in January or February when applications for graduate schools are due. Very few clinical training programs are eclectic, and the student will be guided towards those schools which are in the image of his or her mentor. The analytic schools, as a rule, cluster in the Northeast; the behavioral ones in the Midwest. It is a great loss to the graduate student to receive one of what should be a diverse world of viewpoints, but the greatest loss is incurred in the lack of context into which the student may place these views. Having little or merely narrowly-defined research and clinical experience, the graduate student may not be aware that opinions expressed are expressions of a deep-seated bias.

At this point, many of the other institutions converge in the budding psychologist's field of vision. The clinical faculty has either the behavioral or the analytic journals lying around--almost never both. The student learns either qualitative (descriptive methodology favored by most non-behavioral schools) methods, or is taught to observe and quantify the observable. In either case, the alternative may be derided as fuzzy-brained, outmoded, simplistic, or may never enter into the conversation. Of course, the internships are roughly divided up in this fashion, as well. It is any wonder that behaviorists laugh and nudge each other if a psychiatrist or social worker mentions the unconscious? At the last AABT, Meichenbaum was

nearly shouted down when he mentioned integration of some non-behavioral principles into the behavioral repertoire. Should we be surprised that most analysts believe that behaviorism is nothing more than the alternating administration of electric shocks and M&M's?

Obviously, the obstacles to an integration of the psychoanalytic and behavioral schools are legion, but it is time for the inevitable Hegelian synthesis. A few people have ventured in this direction, and the second half of this paper will address their efforts.

Discussion and formal research in the area of rapprochement has proceeded on several fronts. The first, most popular and least satisfying, area is that of the treatment outcome study, specifically designed to compare treatments across orientations. The second has been the content analysis method, which parses the verbal interactions of the client and therapist. Finally, a couple of theoreticians have taken on the task of comparing the vocabulary and techniques of the two schools and attempted a translation of sorts in order to erase the superficial differences and to highlight the true dissimilarities.

The outcome study considered important in comparative therapies is that done by Gordon Paul in 1966. He targeted anxiety as the focus, and used as outcome measures a large battery of self-report tests, autonomic indices of anxiety and physiological arousal, and a behavioral check list of performance anxiety. There were five therapists, interestingly, none was identified as behavioral in orientation, but were Rogerian, neo-Freudian, and orthodox Freudian. The three treatments consisted of insight, systematic desenstization, and placebo, plus two control groups.

The basic problems with this research concerns the choice of therapists and the inadequacy of quality control; the therapists were asked to record the frequency with which they used a variety of techniques, but, as Hans Strupp noted, "As is well known, most dynamic therapists are not primarily concerned with the alleviation of an isolated symptom and they do not accept patients on that basis. Paul apparently induced them to work toward his goals rather than toward their own."[3]

Paul insured success for the behavioral method in this study by several methodological oversights. First, by using only insight-oriented therapists to deliver the behavioral treatment, he guaranteed that the treatment would not remain pure; no psychologist can unlearn years of training merely to meet a set of procedural expectations. This is part of the reportage problem we addressed earlier; a reader cannot be sure of exactly what the therapists were doing. In this case, that is the all-important question, it is the major focus of this piece of work. Second, the implicit bias of the research is behavioral from the onset. The focus is on a targeted behavioral index of anxiety, which is measured behaviorally. Of course behavioral methods will win out in behavioral research; it's a setup. One wonders why this research was not followed up with a study in which a team of behaviorists is hired to deliver insight therapy.

The other work in comparative treatment outcome substantiates an unpopular conclusion: namely, that this is not the methodology which will foster greater understanding of the superiority of one approach over another, much less bring about an integration. Even within the behavioral subgroups, the variables used favor one of the methods involved. For example, a

study of the relative methods of cognitive therapy and social skills therapy in the treatment of social anxiety (which is, by the way, not a hypothetical study, but one in which I was involved last year) has to employ dependent variables which respond both to cognitive and social skills performance. So what is the outcome? Within the group receiving social skills therapy, there is improvement on the social skills measure, and no change on the cognitive, or perhaps some seepage occurs and there is improvement on the latter, as well. We assume the situation is reversed in the case of the cognitive group. We have learned little about the mechanisms involved in change, and if no significant (that is, statistically significant) differences are displayed, we may never read the study. Apparently, the fact that two treatments are interchangeably effective is of no interest, if we may take journal editorial policies as an example.

A more fruitful area has been that of content analysis. In 1979, Brunink and Schroeder investigated verbal therapeutic behavior of 18 highly-trained analytic, gestalt, and behavioral psychologists and psychiatrists. The therapists were compared along six dimensions: type of therapeutic activity (structuring, exploring, interpreting), temporal focus (immediate present or historical past), interview focus (client, therapist, or their relationship), degree of initiative (weak to strong therapist initiative), communication (the presence or absence of rapport, empathy, or understanding), and therapeutic climate (supportive, neutral, or nonsupportive). They state their results as follows: "Compared to the other therapists, gestalt therapists provided more direct guidance, less verbal facilitation, less focus on the client, more self-disclosure, greater initiative, and less emotional support. Behavior therapists and psychoanalytically oriented

therapists were surprisingly similar in their style of therapy, with the interesting exceptions that behavior therapists provided more direct guidance and greater emotional support."[4]

This is only one study, but it does some damage to the existing stereotypes, while perhaps providing avenues for a closer alliance between analysts and behaviorists. A closer examination of the data reveals no difference between the past-present focus among the groups; the primary context was the here-and-now, with roughly ten percent of the sessions spent on the past. The relational aspect of the therapy was found equally important in both groups. Even the supposed analytic strongholds of neutrality and interpretive remarks were shared by the behaviorists, and with the same average frequency.

In what is undoubtedly the most ambitious theoretical work of integration done to date, Paul Wachtel (who wrote his book in close consultation with the behaviorists at SUNY-Stony-Brook) further reduces the distance between the two orientations through a mixture of common sense and syntactic manuvering. One of his major topics is the transference. Most analytically-oriented therapists would maintain that the extensive assessment and active confrontation favored by the behaviorists would dilute, destroy, or otherwise interfere with the blank screen projection which is the major mechanism for change in the analytic tradition. Wachtel recommends a less rigid definition of the client-therapist relationship, suggesting "(a) that a greater range of permitted therapist behavior will lead to a greater range of patient's potential ways of being becoming manifest in the sessions, and

(b) that at the very least it is necessary to recognize that what is revealed by remaining constant is not "the" true underlying personality, but those aspects of the patient's possible modes of adaptation that are likely to occur in a context of frustration and minimal feedback."[5]

On the other hand, behaviorists will have to acknowledge that something of an interpersonal nature actually occurs in the consulting room, regardless of whether they attend to it or not. The therapist is not merely an instrument for instructional delivery of this or that technique. Part of the difficulty lies in the mystique which has developed around the transference; if the transference could be conceived in a less emotionally-laden term to include all therapist-client interactions, then everyone could begin to speak a common language.

A useful device, expanded but not invented by Wachtel, is that of simultaneous translation of the vocabulary of one school into that of the other. This is not as gratuitous as it may sound; in my consulting, I found it the only method of communication between behaviorists and analysts. The schism has gotten so large that there are literally no terms upon which the clinicians in question can agree. At the Veteran's Administration Hospital in which I worked, it was painful to observe a meeting between the analytic staff psychiatrist and the behavioral staff psychologist. Since they were often assigned to the same treatment teams, this lapse was often troublesome.

According to the Wachtel schema, it need not be. Let us take a simple example first: the reduction of tension. We may immediately associate this with a progressive relaxation technique, and thus chalk

this area up to the behavioral side. But is the analytic situation itself an in vivo experience of tension reduction? The room is darkened, the voices are calm and quiet, there is considerable silence. Analysts deal with relaxation implicitly, not explicitly. That does not seem an insurmountable obstacle to rapprochement.

Or, consider the probing of the unconscious for absent memories. While it is true that the behaviorists would consider this activity a waste of time, the technique used in psychoanalysis for reaching these stored images is remarkably close to systematic desensitization. In both processes, there is a gradual, temporal move toward an aversive event, or memory, or object. In both, the therapist is continually receiving feedback from the client as to how fast is too fast, in time and in tone. When the goal is reached, a breakthrough of sorts is expected, with a consequent reduction in the perceived aversiveness of the object in the eyes of the client.

Finally, reinforcement is omnipresent in the analytic repertoire. Interpretation is a form of attending to the positive or to a belief held by the client. Restating what the client says serves the purpose of calling it to attention as a potentially useful path. Silence on the part of the therapist can be interpreted as passive acceptance of the previous remark; this is a passive sort of reinforcement.

These equations highlight several similarities in the goals of behaviorists and analysts. First, both seek to increase the constructive aspects of the client's feelings, behaviors, and thoughts, and to decrease the frequency of defensiveness, maladaptive behaviors and resistance to the therapy itself. Second, both seek that which is perpetuating the client's discomfort;

the search is carried on differently, but the goals are identical. Third, both seek to engage the client and keep the client in therapy for as long as is necessary; the latter is achieved by giving the client a progress report every so often. This may take the form of direct compliments or subtle interpretations.

If the feuding is to end soon, this common language needs some work. As psychologists, we will benefit from some cross-fertilization of ideas; already, the behaviorists are showing signs of admitting cognitions into their cosmology and the analysts are looking for more structured therapy methods to reduce treatment time. But they still talk to each other very little, and subscribe to much of the defensiveness and resistance which would be interpreted as signs of psychopathology if they were the clients and not the psychologists.

Notes

1. Wachtel, P. Psychoanalysis and Behavior Therapy: Towards an Integration. New York: Basic Books, Inc., 1977, p. 4.
2. Ibid., p. 105.
3. Strupp, Hans H. Psychotherapy: Clinical, Research, and Theoretical Issues. New York: Jason Aronson, Inc., 1973, p. 695.
4. Brunink, S. A. and Schroeder, H. E. Verbal therapeutic behavior of of expert psychoanalytically oriented, gestalt, and behavior therapists. Journal of Consulting and Clinical Psychology, 1979, 47(3), 572.
5. Wachtel, op. cit., p. 70.

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"Learning to Listen: Modifying a Psychoanalytic Psychotherapy"

A paper which was presented as part of a symposium entitled Integrating Behavioral and Psychodynamic Therapies: Issues in Training and Treatment at the 90th annual meeting of the American Psychological Association, Washington, August, 1982.

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2.10.1 Behavioral Psychotherapy/Treatment Methods
2.10.2 Dynamic Psychotherapy/Treatment Methods
2.12 Training

Learning to Listen: Modifying a Psychoanalytic Psychotherapy

In psychoanalytic psychotherapy, a relationship unfolds whereby the interpersonal and intrapsychic conflicts, wishes, and fears of the patient are open to analysis, understanding, and eventual resolution. Through examination of the patient's feelings, thoughts, and actions, as well as the therapist's own emotional responses, attention is drawn to the recreation within the therapy relationship, of the idiosyncratic and often unsatisfying patterns of relating that have been troublesome to a patient.

While there is some debate in the literature, particularly with regard to the treatment of borderline patients (Robbins, 1980; Kernberg, 1980), about assessing the extent to which interpretations, as opposed to supportive or behavioral interventions, might be appropriate for an individual, there is little description of the process by which a therapist reaches and implements a decision to alter the structure of a therapy. In addition, there is little technical explanation of what specifically needs to be changed in a more traditional therapy, why and how that can be done by focusing more on behavior and reality, and the implications for both patient and therapist of such an alteration.

I will present the case of a 28 year old young man, seen in individual psychoanalytic psychotherapy by me for 14 months in a training clinic. In this therapy, intensification of the transference, and interpretations of defenses, anxieties, and impulses, did not help move the patient significantly toward growth, but instead unnecessarily heightened pathology, and undermined his coping strategies. The five month process in which it became increasingly clear that a more traditional analytic therapy was not optimally therapeutic, at least not in a once-a-week outpatient setting, will be discussed. The focus will be on the

dynamics within this relationship, the close to intolerable anxiety for both patient and this therapist, and on the specific ways in which an essentially interpretative style proved to be nonproductive for this patient.

Peter, a 28 year old graduate student came into therapy to deal with stress related to his separation from his family 2500 miles away, and to his recent separation from a girlfriend. He reported dissatisfaction with all his relationships, and in particular, was beginning to see that he was alienating himself from everyone in his graduate department. Peter was also becoming increasingly overwhelmed by his intense and confusing wishes to go out of his way to do favors for, please, and accomodate others, and his concommitant wishes to hurt people when he felt he was being taken advantage of.

As a relatively inexperienced therapist, I was startled by my initial reaction to Peter, which was one of powerful distrust and dislike. After one session, I recognized that the affective experience of being in the room with Peter was different from what I had experienced with other patients. With Peter, I very quickly had to get in touch with, and accept, the more distasteful and distrustful parts of myself, a process that enabled me to empathize, respect, and grow to genuinely care about a person who managed to drive almost all other people away from him.

Much of the initial period of the therapy was characterized by confusing and contradictory events, related in part to the confusing, contradictory, and frightening feelings Peter experienced. In addition, in his effort to find the help he deeply wanted, Peter involved other mental health agenicies in our work, complicating my attempts to discover how to work best with him. Very early in the therapy, Peter expressed considerable dissatisfaction, anger, and frustration with

the way we were working. He requested advice, direct and simple answers to his problems, and wanted me to tell him what to do and say. My interpretative stance pulled for the emergence of his need to rely on others to tell him who he was, what he thought and felt, and what he wanted for himself, a dependency he was finding troubling and self-defeating in his current relationships.

As Peter revealed the thoughts that were on his mind, it became clear how adopting the ideas of others functioned defensively for him. Given the leeway for expressing his own thoughts and feelings, Peter feared not only that he was boring, uninteresting, and stupid, and that others would be as critical and judgmental of him as he was of them, but that he was no one without someone telling him who he was. Peter filled the sessions with disturbing themes of sexuality, aggression, hatred, and violence. He described incidents of violence and abuse toward his brother, sisters, and ex-girlfriend, and questioned whether he was a bad person or a criminal. In an early session, Peter said, "...Maybe I'm a criminal...maybe I'm not a criminal. Maybe there's something wrong in my head that I have these thoughts. Maybe I should be put behind bars--I don't relish the thought of being in jail, but maybe I have to protect either myself from society or society from me."

Peter often terrified me, both by the content and associations of his sexual and aggressive feelings, and by the emotional experience of sitting in the room with him. Peter's thoughts were loose and flowed one into another, usually without division into sentences, and sometimes without too much logical connection between them. Peter once described himself as having every problem in the world, and despite both our efforts to focus and contain his feelings, each early session seemed to have some strain of each of those problems in it.

In our second session, Peter said that he had a "basic fault".

He said, "If y ou have a basic fault in you, no one will like you". Although Peter did not know how apt his self-description was, the basic fault, as Balint (1979) described it in his book with that title, and as Peter seemed to experience it, has to do with trust, and a breach of trust in an early relationship that affects all future relationships. It has to do with a feeling that there is something wrong, some deficiency because someone else has defaulted on him. In therapy, this often takes the form of a desperate hope that the therapist will not fail him, and I would add, a profound fear that the therapist cannot be trusted.

For Peter, trust was always a central issue. It seemed that he was hurt so badly that it was painfully difficult for him to trust that anyone, that I, would not hurt him again. It was also hard for Peter to trust himself that he would not hurt others in fear and retaliation. In addition, Peter's concerns about whether or not I was helping him as best as I could interacted with both the realities of a training clinic, where supervision, tape recorders, and one-way mirrors are salient, and with my own uncertainties as a therapist-in-training about whether or not I was helping him enough. With Peter's precarious sense of trust that often reached paranoid proportions, and with my own struggles to trust a young man who scared me on many levels, it seemed appropriate and challenging to aim for Peter's participation in a mutually trusting relationship as a goal of the therapy.

Peter experienced most relationships as sado-masochistic ones, and early in our work, I found myself feeling like his complementary partner. At times Peter perceived me, and I felt like, a sadistic limit-setting rigid therapist, requiring that he masochistically swallow his frustration with the work, out of the fear that I would kick him out of the therapy. He felt like he was masochistically trying to trust me,

despite the pain it cost him. Alternately, Peter experienced me as a masochistically submissive therapist, trying to accommodate to him because of his threatening demands, and because of his continual threat to leave.

Peter's anger and continual demands for advice served many functions in the therapy. They demonstrated one defense by which Peter kept his troubling feelings and thoughts at bay and untapped. Equally important were the ways that Peter's demands functioned constructively in the work, eventually indicating to me that some changes were needed in the therapy. Furthermore, Peter's persistent complaints, as well as his more unconscious reactions to limitations in the therapeutic relationship provided the opportunity for him to acknowledge his anger with me. Various confrontations with the limits of our working relationship dramatically served as vehicles to explore Peter's fears that his anger would wipe out all the good feelings he had, or that his anger would, as it had in the past, hurt himself or me. More specifically, Peter feared that if he was angry at me, I would not remember that he also had good, caring feelings, and would therefore tell him he could not continue therapy. Exploration of Peter's anger allowed him to reach, and begin to integrate, the profound insight that he could be angry with and care about the same person at the same time. Peter continued to grapple with this developmental achievement in relation to me and to other important people in his life for the remainder of the therapy.

Despite some gains that were being made, it grew increasingly clear that Peter's heightened feelings toward me were escalating his anxiety, leading him to become more bizarre in both content and affect, and pushing me to withdraw emotionally to protect myself from the depth of his regressed needs. Slowly, and not without pain for both of us, I responded to Peter's underlying desperate plea for me to control the

therapy, to structure it in such a way that he could begin to learn the interpersonal skills he needed to be able to manage his life and take care of himself.

Kernberg (1982) describes modifecations of three essential psychoanalytic therapeutic techniques: The therapist's neutrality, the use of interpretation as the major therapeutic tool, and the analysis of the transference. The therapy with Peter necessitated modifications in all three realms.

Two clear difficulties emerged with my initial interpretative stance and my analysis of Peter's transference. Peter experienced interpretations of his projections as confirmation that his worst suspicions were true--that in fact I thought he was bad or stupid or an intolerable drain on me. In this way, Peter's anxiety escalated, his distrust and fear mounted, and he became increasingly more disorganized. He was unable to make use of the healthy aspects of my functioning, but rejected them, envious of me, but also fearful that I was not acting in his best interest.

Peter was clearly not benefiting sufficiently from my efforts to understand and contain his thoughts and feelings. The intensity of his feelings blurred distinctions between fantasy and reality, a regression that problematically affected his outside life. He needed me to structure and focus our relationship, essentially to function as his ego when he could not rely on his own. He needed me to teach him how to translate his feelings into socially acceptable behavior, a complex skill he unfortunately lacked.

The first five months of therapy with Peter left me carefully considering my limitations as a therapist-in-training in a once a week setting. I evaluated the anxiety we both confronted, and I more clearly assessed the organizing capacities Peter lacked. Because the

nonproductive ramifications of these constraints were increasingly apparent to me, I implemented some major modifications in the structure of the therapy.

Our new structure consisted of Peter's presentation of current or past concerns, mutual exploration of an underlying theme, accompanied by discussion of coping strategies. I helped Peter to understand how and why he got himself into particularly stressful situations, but only after we explored specific behavioral and interpersonal skills he might use to deal with such situations. Relational or transference interpretations were made much less frequently, and only when I could sense that Peter could both tolerate and be helped by them.

Peter adjusted to the modification of the therapy remarkably well. After some anticipated distrust, anger, and fearfulness, Peter became notably calmer, better organized, and less anxious within sessions. This reorganization enhanced and strengthened our working alliance, and increased Peter's capacity to trust and accept my interventions, thereby helping him to better organize himself outside the sessions. Although I still heard Peter's distortions and projections, I chose not to encourage a potentially constructive regression through my neutrality and interpretation of them. Instead, as Kohut (1977) and others (Tuttman, 1979) have suggested, I avoided our previous struggles in which Peter experienced my interpretations as my "depositing" his projected feelings into him, and responded by understanding his feelings, explaining what I saw as contributing to them, and providing a more reality-focussed reassurance. For example, in acknowledging one aspect of Peter's anger and unconsciously communicated fear that I was taking a vacation in order to hurt him, I directly told Peter that although I was not leaving because I wanted to hurt him, I knew that my leaving

hurt him very deeply.

Peter progressed well as I used reassurance, support, and even advice to help improve his basic skills in keeping appointments and committments, getting his school work done, and being more responsible. For example, a few weeks after we changed our working style, Peter came to a session, apparently quite troubled, and requested that we change our permanent meeting time. It seemed that he had just scheduled another appointment with a professor that made it impossible for him to get to therapy on time. As the session unfolded, Peter gave evidence to suggest that the time he had arranged with his professor was not as permanent as he initially presented it. I let Peter know I was trying to understand his request and explained that was why I did not immediately try to see if we could reschedule. As I listened to him, I could conceptualize the angry components of Peter's request, and I understood that he was trying to see if I could maintain control of the therapy without being sadistic. I sensed, however, that Peter needed something more direct than my interpretations of the meaning of his request within our work, and so I chose to intervene in another way.

I reassured Peter that I did not want to be unreasonable, but wanted us to try to understand the predicament he got himself in with two conflicting committments, since that was something that he did repeatedly. We looked at the reality of his two commitments, and together evolved a plan that would necessitate our changing our time only if he could not rearrange his second meeting. We discussed in detail how he could unoffensively let his professor know that he had a previously-made and overlapping appointment. Only after we negotiated concrete plans did we move to some of the more complex relational sequences that contributed to Peter's self-reportedly frequent irresponsibility. Peter could respond to this less structured exploration, both because I chose not to highlight

his feelings toward me, and also because he felt more settled about what to actually do.

Although Peter never missed a therapy session without telling me in advance, he typically missed other appointments, had trouble making and keeping committments, and tended to be irresponsible. I became better able to see that Peter's difficulties concentrating and organizing had as great a role as his underlying conflicts did in some of the mild calamities he constructed for himself. Therefore, I suggested that Peter buy a notebook in which he could write assignments and appointments, and whenever it seemed necessary, I directly helped Peter structure his time and organize a strategy to meet his responsibilities. I initially feared that such straightforward help would be infantilizing, but I quickly saw the positive consequences this structuring had on Peter's life. I recognized Peter's distress and anger at needing me for something so basic, but I could also see that he was grateful that I recognized his stress with what he could not manage. Peter needed me to intervene in that direct a way less and less, yet we continued to deal with themes related to his inadequacies. With my supportive questioning and careful containment of Peter's more loose associations, Peter was able to sort out some of his feelings about his life, his strengths and weaknesses, and even the developmental sources of his troublesome patterns of relating.

Although the dynamics of these troublesome patterns were generally recreated in the therapeutic relationship, comments were made on that level only when they could significantly alleviate Peter's anxiety. Because interpretations were not aimed at the same depth as they were prior to restructuring the therapy, Peter became better able to make use of them and to arrive at insights on his own. Within about four months, it became evident that Peter could provide more of the structure

within the sessions that he earlier needed me to supply. As his cognitive and organizing abilities strengthened, and his trust in me became more solid, and at times when Peter's current stresses did not require all of our attention, Peter was able to tolerate more relational interpretations, which I always cautiously balanced with support and attention to his reaction.

It was actually quite moving to me to see how much calmer Peter became after the therapy was restructured, how my responding in a new way to all his requests for a different kind of help made such a difference for him, and how we managed to deal with many of the same issues, albeit in a structured format. Although this new style initially seemed unlike therapy as I had previously conceptualized it, I quickly benefited from the relief and gratification we both experienced with our new way of working. I learned how to judge when my interpretations were helpful and how to make them sensitively without abandoning my more open, reasonable, reality-checking and supportive stance, and I saw Peter improve.

I learned to talk more easily and freely with Peter, thereby allowing him to observe and absorb my thought processes and problem solving capacities. I educated Peter about his feelings, telling him he could feel whatever he felt and still not be a bad person. Balint (1979, p.93) wrote "...the child will be able to express with ease only such feelings, thoughts, experiences as are commonly experienced by his parents...", and so, in the therapy, I used my awareness of the range of feelings Peter communicated unconsciously and interactively, to teach him about his own emotional capacities. Peter benefited from learning the distinctions between having feelings and acting on them, and could appreciate that while it was safe to tell me whatever was on his mind, other people would probably not understand him in the same way.

After about a year of therapy, Peter encountered serious interpersonal and academic difficulties which resulted in considerable uncertainty about his plans to remain in the area. It seemed important that we have the opportunity to work through a pre-arranged termination process, and so a termination date was agreed upon. We used the last two months of the therapy both to concretize and structure Peter's plans (a focus especially helpful as he became more disorganized and stressed in the midst of much uncertainty in his life), and to explore any feelings he had in reaction to our ending relationship. Peter responded to his realization that therapy would end with fears that I might force him out of therapy immediately, and with feelings of sadness, rejection, and hurt, which led him to feel angry and occassionally withdraw. Peter's ability to acknowledge some of these strong feelings in the context of our work provided evidence for his rudimentary, but nevertheless developing, capacity to experience loss.

Despite the intensity of Peter's fears of closeness, his profound distrust of others, and the powerful ways in which he aroused distrust and dislike in others, Peter progressed sigrificantly in the therapy. He was able to improve his social skills and develop his organizing abilities. Peter began to understand some of the ways he alienated others and to reach some important insights about his intensely ambivalent feelings toward people on whom he is dependent and to whom he is grateful. Probably most important to Peter's growth was that he was able to tolerate a close, albeit occasionally disruptive, relationship with me for over a year.

Although Peter was able to use the therapy productively, he left without a clear sense of who he was or what he wanted for himself. He was still very isolated and confused, and had a limited capacity for forming and maintaining relationships. Because Peter continued to get

himself into troubled interpersonal situations, and because he still lacked some very basic social skills, I suggested that after a break, he seek therapy again.

While the progress Peter made was gratifying, and my own growth as a training therapist was considerable, there was also a tremendous loss for me entailed in this transition. I had sometimes thought of Peter as a "28 year old 6 year old", even as "emotionally retarded", and early in the work, had to struggle with accepting what he did not know and could not do. Once I was able to recognize that I needed to reorganize the therapy, I finally began to appreciate his limitations deeply enough to benefit Peter. I became able to hear his sadness about his own deficiencies, his frustration and jealousy about his inability to manage the responsibilities he saw that other people could handle. Instead of avoiding his disorganization and his needs, I learned to recognize them, address them, and work with him to discover his strengths without minimizing his limitations.

More personally, I experienced a loss because I did not want to accept my own limitations as a therapist, or give up my just-burgeoning omnipotent fantasies about how I could help people. I wanted to believe that deep understanding was a panacea. As I accepted that Peter needed something more basic than my interpretations, that he might never have the capacity to relate to people the way I do; as I accepted Peter's child-like qualities, I was losing an only recently developed sense of myself as a certain kind of psychoanalytic therapist. Accepting and experiencing these losses helped me to more realistically broaden my definition of psychodynamic therapy, and to learn about my own capacity to be flexible enough to respond differently to different patients.

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