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ABSTRACT

This paper, presented as a part of a symposium on the use of multiple therapies with a single client, conveys the author's personal experiences in making a gradual transition from psychodynamic therapy to a pragmatic blending of psychodynamic and behavioral treatment approaches. Two case studies are presented to illustrate the use of the two therapeutic approaches. The first case study presented describes the 18 month treatment of a 19-year-old woman diagnosed as paranoid schizophrenic. The second case describes the treatment, over a 2-year period, of a 20-year-old man suffering from incapacitating attacks of anxiety, related to fears of homosexuality. The impact of the blending of treatment approaches is discussed from the view point of patient needs and the training of student therapists. The author concludes by emphasizing the need for student and colleague openness. (BL)

THE PRAGMATIC BLENDING OF PSYCHODYNAMIC AND BEHAVIORAL TREATMENT APPROACHES

A paper presented as part of a symposium entitled Multiple Therapies with a Single Client: Evidence and Implications for Theory, Treatment and Training at the Eastern Psychological Association Convention, Philadelphia, April, 1983

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During the past several years my therapeutic work has undergone a rather dramatic transformation. Oddly enough it took me some time to recognize that my predominantly psychodynamic approach to treatment was being altered in ways that might actually shock some of my former psychodynamic supervisors and teachers. Much to my surprise I found myself incorporating some behavioral techniques into my work, and even more surprising was the success that was resulting from such integration of approaches.

For years I had thought and functioned quite comfortably with the belief that traditional psychodynamic treatment techniques were the only true and effective ways of doing therapy. I knew that behavioral approaches existed, but I had been successfully convinced that they really only worked for circumscribed problems such as phobias, and even then symptom substitution would very likely occur following extinction of the phobic responses. In my graduate program during the early 1970's a major curriculum innovation occured when a behavior therapy elective course was introduced; ironically students had the option of choosing the behavior therapy course or an animal behavior laboratory. I chose the latter, and spent the semester working with chameleons.

During my internship and two years of postdoctoral clinical work at a very psychodynamically oriented facility, one occassionally heard talk of behavior therapy, but once again it was considered appropriate for a small and quite specific group of problems. I also recall behavioral approaches such as systematic desensitization and token economies being

joked about. We all knew that early life experiences determined adult pathology, and that curative results could be achieved solely through exploration of these experiences, as well as analysis of resistance and transference and the other dynamic techniques. I too became caught up in such techniques and their associated jargon, but over time began to experience a growing disenchantment, as I found myself feeling increasingly constricted by theoretical affiliation.

I began to recognize that the treatment plans I was formulating for patients often had more to do with my own theoretical biases than with their treatment needs. For many patients the psychodynamic model was sufficient, but for some it did not go far enough in helping them achieve life change. Consequently I began expanding my repertoire, altering my therapeutic style so that with some patients I was being much more directive. Though at the time I did not define such alterations as being behavioral, it is apparent in retrospect that indeed I was covertly incorporating many of such strategies into my work.

The treatment of one particular patient stands out for me as a critical turning point in my development as a therapist. At the time of her admission to the hospital this young woman, whom I will call Mary was 19 years old and presented with the symptoms of paranoid schizophrenia. Most prominent in her symptomatology were hallucinations and the delusion that she was accompanied everywhere by an imaginary friend with whom she would converse, cajole, and occasionally disagree quite audibly. She was enraged with her family and other associates who objected to her bizarre behavior and emotionality, and she asserted that others were envious of the closeness she had achieved

with this friend, and that they were therefore attempting to destroy the relationship.

In our early work together she was quite belligerent, as she perceived me as one of the enemies. As I took the history from Mary and from her parents it became clear that Mary had a lengthy history of isolation. She was the youngest of four children; her three older siblings were all boys and there was an eight year age gap between Mary and her closest brother. It was apparent that Mary's birth had not been planned and that her arrival into the family caused considerable familial disruption. Numerous anecdotes were presented in which Mary was the object of sibling ridicule and exclusion, and in many ways it seemed that both parents also participated in this process. In school, Mary also came to be perceived as different; she had few friends or playmates and relied increasingly on autonomous activities including daydreaming as sources of personal entertainment. At the age of seventeen Mary fortuitiously met a very kind neighborhood woman, Jane, who for a brief period of time showed an interest in Mary unlike anything she had previously experienced. Jane suddenly was perceived by Mary as her rescuer, as a person who would care for her in every way. The intensity of Mary's response understandably frightened Jane and resulted in Jane distancing herself from Mary. Unbeknownst to Jane she very much remained with Mary at first in fantasy and subsequently as part of a fixed delusional system.

What a terrific case for exploratory therapy. The connections seemed unbelievably clear, and one might naively presume that by means of a long

working through of the issues, Mary would come to understand the roots of her need for Jane and gradually become able to dispense with this fantasy and initiate more appropriate interpersonal relations. An important additional piece of information is the fact that phenothiazines were immediately prescribed and proved quite effective in reducing the psychotic symptomatology; however the imaginary friend remained an incorrigible component of Mary's thinking.

My treatment of Mary lasted eighteen months: six months of inpatient care consisting of twice weekly individual therapy sessions, followed by one year of treatment as an outpatient with weekly sessions. After one month of arduous attempts on my part at doing exploratory and interpretive work, it became evident that I continued to be seen as one of the enemy who was attempting to take Jane away from her. At that point I realized that she was correct and that my approach was not adequately respecting her current needs for support and direction. Mary was a patient on a twenty person ward and she was as isolated there as she had been for her whole life. Upon recognizing this, I redefined the treatment goals so that improvement of socialization skills would become a priority. What Mary needed most in life at that moment was to learn how to be with and talk with other people. In retrospect it seems such an obvious need, but at the time it felt like a big risk to initiate therapeutic techniques specifically aimed at a behavioral target. I chose not to abandon the exploratory and interpretive tasks but rather to look for ways in which I might blend those tasks with the new efforts which were geared towards improved socialization. Mary's

response was immediately positive; she desperately wished to become more comfortable in her dealings with others but felt completely ignorant about how to go about it.

In the months that followed we began to do behavior rehearsal in which Mary and I would role play various social interactions and she would subsequently proceed to test out these new strategies in real situations. There were the typical problems and disappointments, but change was nevertheless being achieved, albeit slowly. The tasks were gradually expanded into areas of familial dealings and finally applying for a job.

Over the course of the six months of inpatient work one very important thing happened. Jane disappeared from Mary's thoughts, and I predictably became the central figure in Mary's life. In this therapy, exploration of the therapeutic relationship became a critical but very complex task. Mary had made a tremendous investment in our relationship and it was imperative to recognize her vulnerability while at the same time help her understand as much as possible the significance of her feelings toward me. Concomitantly there were the real life needs to get Mary out of the hospital, into a living situation and placed in a job. It would take too long to review in detail how all of these forces were balanced, but what is clear is the fact that major exploratory and interpretive work was blended with direct behavioral interventions geared toward specific targets.

As the year of outpatient work progressed this dual focus was maintained. Teaching Mary how to function autonomously was done simultaneously with consideration of issues of termination. It was necessary to carefully work through

Mary's feelings of loss so as to obviate her need to create a delusional system regarding our relationship subsequent to termination. We spent many months on this issue while at the same time collaborating in our attempts to alter Mary's behavior. The therapy ended on a most positive note; though it was a painful loss for each of us there was a rewarding sense of hope and optimism in our final sessions. About every two years Mary writes to me to let me know that things are moving along in her life satisfactorily.

Ironically it was only in retrospect that I came to realize that for pragmatic reasons I had been blending complementary therapeutic strategies. I realize that there is nothing particularly novel in doing such, and that many therapists probably do similar things in therapy all the time. However it seems that only in the past few years has there been clear articulation regarding such integration of differing therapeutic styles.

I recall coming across Paul Wachtel's book, Psychoanalysis and Behavior Therapy in 1978. As I read it I felt a tremendous sense of liberation, a sense of permission and encouragement to proceed with the blending of approaches which had become such a sensible and comfortable style for me. Around that time I began a two year treatment of a twenty year old male, Steven, who requested treatment for incapacitating attacks of anxiety, related to fears of homosexuality. Though Steven had been valedictorian in high school, he was struggling to maintain passing grades in colleges. He was the youngest of three male children from a fairly high

pressured family. Both parents were successful professionals, and his two older brothers were succeeding in their endeavors. Approximately a year prior to starting treatment, Steven's father had had a serious heart attack, resulting in tremendous family turmoil. Though Steven had never felt close to his father, he was startled by the intensity of his reaction to the possibility of his father dying. Around this time he started to become concerned that he might be homosexual. Though he had not previously had any homosexual desires or fantasies he began to develop obsessional thinking about the matter. He increasingly perceived himself as potentially homosexual, and such thoughts would send him into recurrent episodes of panic. He had no desire to make homosexual contacts, but found himself struggling with homosexual fantasies which he found very alarming.

Though Steven's father regained health, Steven himself became increasingly disturbed. He began to experience academic problems, primarily due to his inability to concentrate. His relationship with his girlfriend of two years became volatile. Their previously achieved harmony was recurrently disrupted as his anxiety and obsessional concern took control of his life.

At the time of intake Steven was in a state of panic; in addition to several physical correlates of excessive anxiety, he was evidencing lability, apprehension, obsessional thinking, and fear of losing control. Initial clinical assessment continued for a few more sessions, during which he persistently defined his concern as being limited to this fear of homosexuality. Historical information was also collected, and a connection began to surface between Steven's presenting problem and his relationship with

his father. Steven was shocked as he began to acknowledge both to himself and to me his longstanding but unsatisfied yearning for closeness with his father. Though he initially dismissed the possibility of this need being connected to his obsessional concern, over time he slowly came to understand.

In addition to the obsessional thoughts there were the episodes of recurrent panic which were impairing Steven's functioning. Though the rich potential for dynamic therapeutic exploration was so appealing to me, I also recognized the need to formulate a treatment plan which would address these incapacitating attacks. In our early work together I tried to determine whether there were any common precipitants for the panic attacks; the one theme which seemed to appear consistently had to do with Steven's doubts about his own competence and adequacy. Even the slightest challenge, be it academic or interpersonal, seemed to provoke the obsessional thinking which in turn led to an episode of panic. Once again there appeared some rich dynamic connections to family issues, such as the pressure to succeed and thereby derive parental respect and affection. Though I was confident that such connections could be made by Steven and worked through, I was concerned about time. Steven's life was becoming increasingly disorganized. He was living on a roller coaster of anxiety and each descent left him more scarred and vulnerable. It seemed clear to me that the best treatment for Steven would consist of exploratory and interpretive work blended with anxiety management. Not only did Steven need to understand that homosexual anxiety might have more to do with self-concept and his relationship with his father

than to do with sexual identity issues, but he also needed some skills for managing the anxiety which was incapacitating him.

Steven needed to develop the skills necessary to short-circuit the panic process while concomitantly becoming sensitive to those experiences or issues likely to set them into motion. In our work during that first year Steven came to perceive the dynamic connections; he also acquired improved self-control through employment of thought-stopping and relaxation training techniques.

After one year of therapy Steven's panic attacks had subsided. Steven became fairly secure in his definition of himself as heterosexual, though homosexual concerns did occassionally come to mind. Most often such concerns could be understood by Steven within the context which we had developed: namely that any experience of self-doubt was able to provoke a dynamic chain reaction in which issues having to do with paternal acceptance and affection would be aroused and translated into homosexual anxiety.

During our second year of work together fewer "behavioral" interventions were used in the therapy context, though Steven continued to carry out relaxation exercises. Our work became predominantly exploratory, though periodically techniques such as behavior rehearsal and problem solving proved both appropriate and effective for specific concerns which arose; they also seemed appropriate to both Steven and myself due to the blended work we had done during the first year of treatment.

During the termination phase the most prominent issue seemed to be Steven's ability to be autonomous and be confident that he would be able

to both translate his insights into action as well as to take control of his own thoughts and behavior.

Summary

My purpose in presenting these two cases is not to convey any startling revelations. In fact I am pleased to note that in the past few years there has been an impressive movement toward rapprochement which has been reflected in an increasing number of books, articles and presentationson the subject. What I have attempted to do was convey a personal experience, one which involved a gradual transition in which I came to redefine my therapeutic style. The most dramatic impact for me has been the recognition of the need to formulate treatment plans which serve my patients' needs rather than my own. And secondly I have learned the importance of conveying this idea to student therapists whom I teach and supervise. It has been my experience that beginning therapists characteristically affiliate with specific therapeutic models, and that such affiliationsare fostered by academic programs which delineate therapy according to such models.

In all likelihood many of the professors who teach courses or therapy practica in behavior therapy or psychodynamic therapy actually work quite flexibly in therapeutic settings. As Grinker (1976) suggested once the office doors are closed, much probably goes on in the psychoanalytic hour that departs substantially from orthodox psychoanalysis. Certainly the same would hold true in behavioral circles as well. One of the points which I would like to emphasize is that we should begin fostering openness

in our students and in our colleagues. Certainly there is security derived from working within a specific therapeutic framework, but I am certain that there are rich benefits to be derived for both therapist and patient when treatment plans are formulated according to common sense rather than theoretical bias.

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