THREE THERAPEUTIC APPROACHES--AND ONE PATIENT

Alfred Adler always advised us to learn the theory and practice of other psychiatric schools. He frequently called off one of his unforgettable Friday evening meetings in order to leave us free to attend a lecture or discussion conducted by a member of a different psychological school.

With this in mind, we presented this incomplete intake interview of one patient, to therapists of three different philosophies for diagnosis and treatment procedures. The various approaches are conditional upon further findings and upon verification of the therapist's first deductions.

We have published this interview with the written approval of the patient.

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The patient is a 30 year old woman, separated from her husband, currently working in a position requiring diplomacy and decision. She is a good looking woman of above average intelligence, who comes for treatment because she has come to recognize that "there are things wrong with me." She has been attending a series of meetings for the families of Alcoholics Anonymous in that she has been married for 2 1/2 years to an alcoholic man. She now recognizes that there must have been something wrong with her at the time she married him and she seeks help with her problems. Her husband is thirteen years her senior. When she married him she did not know he was an alcoholic. He could not hold a job and was becoming violent.

Presenting Problem: "Many problems I have are coming to the surface. I am married to an alcoholic. We have been separated for the past two months. We agreed that if he could stay sober, I would come back. I talk to him on the phone every day and go to dinner with him. He constantly urges me to live with him. I try to explain I don't want this kind of relationship now. I brood if we argue. I want to tell him if he asks me to come back again, I will stop seeing him altogether. I can't bring myself to do this."

Social: Patient was born in a small town. Her parents were divorced when she was 12 years old. Patient is the oldest of four siblings, having two sisters and one brother. When the parents divorced, patient and her two sisters lived in a children's home for two years. The little brother remained with his mother. The parents are close to 50. Patient's sisters are very close in age to her. Patient was always proud that her parents were younger than parents of her peers. The mother was described as very impatient and short-tempered, often slapping the children. The father was rarely home when patient was awake. He worked long hours in his father's restaurant and stayed out gambling. In the children's home, patient was one of the oldest children and one of the few Roman Catholics. She hated it there. She fought constantly and terribly with her sisters. She felt ashamed of the ill-fitting institution clothes. She resented her father's favoritism to the sister nearest in age to her.

Her father remarried and after she left the institution, she and her sisters went to live with the father and his wife. The step-mother was described as an aloof, cold person. Patient and her sisters wanted very much to get along with the step-mother but never could. The step-mother suffered convulsions. Patient was afraid to go places with her for fear the step-mother would have a seizure.

As a child the family lived near the paternal grandparents who loved patient very much and wanted to adopt her. At age 11, she suffered mild polio. She enjoyed the attention she got with the illness from mother and friends in school. She always did well in school. In high school, she was popular and was known for her sense of humor. Boys were drawn to her but only as friends. She always had boys around her and this drew girl friends. However, the boys never dated her but went with the other girls. She had many friends but always felt a little out of things and that she had to initiate social contacts.

In college, she was pressed for money, worked in the dining room, and constantly worried that she would not be able to make both ends meet.

There is a history of two abortive suicidal attempts. One occurred at the age of 21 when a boy friend she loved left her. She took many kinds of pills at one time, but was not certain they would be lethal. The second attempt occurred in February 1963 when a reunion with her husband failed in that he resumed his drinking. She turned the gas on but then turned it off.

Earliest memory: "We were in the basement. It was cool. Mother's mother came and brought watermelons."

Patient worries she has no children but is afraid to have children under the present situation.

Patient had been married about 2 1/2 years when she appealed for help. As a result of both parents' remarriages, she now has four half-siblings.

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The following tentative analyses are based on conclusions drawn from clues (symptoms) presented. But if the patient's behavior does not support these provisional conclusions 100%, then the therapist, not the patient, is wrong.

THE ADLERIAN APPROACH

by Nahum E. Shoobs

I will try to discover her goal and life style through an examination of her family constellation and her early memories. Ordinarily, I would use the clues gained from her dreams as well as her behavior pattern both during the interview and during her life--past and present. No dreams are presented. Only limited bits of information are offered as to her behavior pattern in this interview.

The eldest child often tries to protect her early superiority even to the point of being domineering. Sometimes she aligns herself with adults by becoming a model child. She may become so reliable that her parents often call her "my right hand man," a polite term for family slavey.

Her early memory reveals, among many other attitudes, her social isolation, her rejection of the community, her exclusion of men, a world of women and her dependence upon adults for obtaining favors, etc. But I would ask for more early recollections before coming to a positive conclusion. Throughout this interview she makes clear how much older adults love and appreciate her--only with them can she be the favorite. How dependent she is upon them!

Diagnosis: Personality disorder. Goal: This dependent person strives for recognition, appreciation and love. Hence in her relation

with adults (during childhood) she was a model child always trying to please them. With siblings, particularly, she sought recognition through supervising, dominating and domineering. She approached adults with hat in hand, but children with "the big stick."

From the very first interview I would encourage catharsis, stirring her to repeat and to discuss her history and her problems so as to acquaint her with herself and her behavior patterns. Since the Rogerian comments or questions by the therapist are framed as summaries of her statements during the interview, she is likely to accept them as her own and to continue talking. This will help make her aware of her habitual faulty responses to situations--to wit: her fear of being left out or shut out by others.

At first, I will use her weakness, her fear of displeasing, of disobeying or of making mistakes, to tell her "what to do" and "how to do it." (We must keep in mind the danger of making her dependent upon the therapist.) But in relation to her husband's demand, "He constantly urges me to live with him," and her answer, "I try to explain I don't want this kind of relationship now. I brood if we argue. I want to tell him if he asks me to come back again, I will stop seeing him altogether. I can't bring myself to do this," we can not resolve her attitude with a "do or don't" answer.

She must learn, through discussion and interpretation, the purpose of her inability to meet this situation. It may be necessary to give her an opportunity to try, through role playing, several ways of responding to her husband's demands. Once she decides on a suitable reaction, it may be necessary to practice her response until she has it under complete control in spite of increasing difficulties.[1]

Thus, role playing will help her develop and practice many specific answers to specific situations. While she is gaining confidence in herself as well as in her therapist she is becoming aware of desirable alternatives. She is also learning to choose one out of the many.

Through verbalization, following role playing and practicing more desirable responses, she is gaining insight into her goal of never displeasing and of striving for recognition and approval (defensive measures). Through exploring her childhood attitudes, I could help her see how she carried these patterns into adulthood--as for example, her relations to her father on her present emotional posture to men. His favoritism to her younger sister and his sending the girls only, to a children's home while her brother went to live with the mother, are possible factors in her fear of being neglected, left out, especially with men.

She goes out of her way to state that she always did well in school. How has she used this ability? Her marks in school were very high yet her father took them for granted. Undoubtedly, through high school and college, she must have been helping male students who, while they enjoyed her humor and accepted her help, dated other girls. She seemed to give help to boys for her own benefit as a bribe to gain their dates. But does she give help for others?

1. After she has control of this situation, she may investigate how she can use her experience as the wife or ex-wife of an alcoholic in any of the clubs run under the auspices of Alcoholics Anonymous.

She seems overly concerned with what she "gets" rather than with how she meets life situations. Instead of being a companion, or enjoying the companionship when on a date, she is tense with fear of doing or saying the wrong thing. Into her ice cream, she pours the bitter source of her fears. Through role playing, verbalization of same and discussion, we continually examine the nature of her relations with her husband and male associates, especially her attempts to appear something different from what she is.

Her frustrations with men sparked her suicide attempts. Hence she must learn why and how she provokes disappointments, and how she can develop the fortitude and understanding to accept future frustration.

We must investigate her activities with the question: Is she still first concerned primarily with the search for recognition or with the demands of the situation? We must encourage more communication with members of her family, including her young half-brothers and half-sisters who need her support. Since they are too young to be rivals, we can turn her supervisory and her dominating tendencies to loving guidance of them. (But she must remember she is not their parent.) Thus we build on her strengths.

We must examine her business relations, discuss the possibilities of advancement, encouraging her to advance herself. We must encourage her to extend her relations with acquaintances through social affairs and the like.

We can summarize our procedures with the following quote:

"Slowly in an atmosphere of security and challenge and under the therapist's guidance patients are enabled to perceive the purpose of their neurotic symptoms and inadequate response. Under guidance, the patient gains strength and the lessening of her fears. The narrow life goal of self protection can become the goal of social usefulness and self-realization."[2]

A PSYCHODRAMATIC APPROACH

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An overall therapy plan is in itself contrary to the theory of psychodrama. The emphasis in psychodrama has always been so much on the "here and now" that each therapeutic maneuver depends entirely on what the patient has just said, done, or implied rather than an adhering to a prepared procedure. Essentially the director follows the patient, helping him to explore feelings that neither the patient nor the director could predict beforehand. The auxiliary egos are present to assist the protagonist in creating a world of his choosing on the stage. The director functions primarily in guiding the group atmosphere so that this exploration is encouraged rather than ridiculed. When the protagonist is blocked however, the director may make suggestions for scenes, etc., on the basis of cues dropped by the protagonist. These suggestions are usually meant,

2. Papanek, Helene, M.D., "Individual Psychology Today," Newsletter of the Council of Psychoanalytic Psychotherapists, February 1965.

not to provide motivation for the protagonist's action, but only to trigger a line of behavior which the director has reason to believe is latent.

One of the most obvious areas for exploration in the case of the woman considered here, would be her pathetic masochistic life role. In adolescence she made herself unacceptable as a romantic partner, although she had the capacity to attract boys socially. She either engineered herself into an unfavorable sociometric position with her girl friends or misperceived herself to be "out of things" while she was in fact "popular". She is a worrier and exploits illnesses. With the exception of her paternal grandparents she has gotten herself hurt in almost every significant relationship which she has established. Her self-destructiveness reached its most dramatic point in her suicidal attempts, although here, at least, she had some awareness of what she was doing and was able to stop in time. She has really been most effectively self-destructive in her marriage. Despite her intelligence and capacity for "diplomacy and decision" she ignored the signs of alcoholism in a suitor and married him. She then fell into the classically futile role of reformer-wife for several years before managing a tenuous separation.

There is little information given about the patient's childhood before her parents' divorce. We know only that during her first twelve years she had to adapt herself to the life of a girl with a chronically angry mother and a father ridden with the twin vices of overwork and gambling. The atmosphere of the marital relationship in which she was reared can be imagined. Eventually it deteriorated to a point where her mother accepted a divorce even though she would have to send three of her four children to an institution. By this time the patient had evidently learned to discharge the frustration of her unsolvable problems by identifying with the destructive forces against herself. Once the direction of this intropunitive pattern was established the further pressures after the divorce certainly helped confirm and solidify her masochism.

Still another factor generated destructive emotion in childhood. Being the eldest, she had an opportunity to develop expectations of exclusive parental love available before the other children were born. Normally, the competition of younger siblings can be fairly easily absorbed by older children unless, as in this case, there is a grave shortage of parental love; just as hungry prisoners quarrel over scraps while well-nourished groups share their food easily. The complete rejection after the divorce in favor of the young brother could not have done much to enhance her love of her brother, her love of her mother, or her confidence and pride in herself as a girl. Some of her sibling rivalry was expressed against her sisters in the "children's home". However, much of the frustration was turned against herself, in feelings of shame in her religion, clothes, etc.

By the time of the failure of the relationship with her stepmother, the father's second wife, the patient was now both victim and partial instigator of the problem. The patient's unconscious wish for the stepmother to have a seizure (die) originated not only from the stepmother's emotional frigidity but also from the buried

hostility against her biological mother and against the institution as an inferior mother substitute.

These hypotheses about the patient's symptoms and dynamics, drawn from the cues in the history, would not constitute content for the early psychodrama scenes. Instead, less threatening areas would be explored first until the patient had developed trust in the group and a need to move on to more significant matters. Here again, it must be pointed out that patients vary enormously in the amount of "warmup" which they require. Many patients will resist indefinitely if forced into areas which are threatening, while others are more courageous than the director himself and become justifiably impatient with a director who is too gingerly about having the group become involved in emotionally intense scenes. Still, the usual style is for the director to approach the areas of central importance, from the outside, advancing at as fast a rate as the protagonist and the group can reasonably tolerate.

Once the patient is warmed up to the point of dealing with major issues it is best to begin with live and present problems. The patient complains that she wishes to use the threat of not seeing her husband as a way of getting him to stop asking for a reconcilation. But, she says, "I can't get myself to do this." One of the greatest problems in an emotional conflict arises from the fact that the opposing intrapsychic forces tend to cancel each other out. The patient never becomes fully aware of either side of the struggle because each rising emotion is countered by the other side. The struggle tends to remain outside of full awareness, while the patient finds herself miserable and indecisive.

In psychodrama we handle this difficulty by splitting the ego during the period of the drama, letting the protagonist play each side successively, while a "double", a sort of alter ego, fills the role of the other side. In this case the protagonist might be cast in a scene with her "double" with whom she would discuss her decision about making the open threat to her husband. She would be instructed to fight exclusively for the option of making the threat, while the "double" would do all in her power to prevent this. Temporarily freed from her usual guilty ties to her husband, the patient could ventilate her desire to threaten her husband, and possibly the the momentum might take her into even further acts of independence which she had not previously been aware of wanting.

Then, by a reversal of roles, she would take the opposite side of the argument; the inhibitory, dependent side. Under attack from the "double", emotions and ideas might come to her which would help account for the masochistic pattern itself and lead her into historical scenes which might be psychogenetically related.

In addition to the well-known psychodramatic reenactments of traumatic scenes with parents, siblings, suicidal attempts, etc., it is important to emphasize the possibility of alternatives to the patient. She is normally expected to act out the scenes with some emotional authenticity, in a way somewhat similar to the way they occurred originally. Then, however, she is encouraged to explore alternative reactions which one might have had to the same situations. If, for example, she always reacted apologetically to her mother's aggression, she might be asked to try handling these same

situations in a different, possibly very aggressive way. Often a patient shows a great poverty of alternatives leaving little capacity for varying her response. In such a situation we frequently request "auxiliary egos" (co-therapists or other patients in the group) to take the patient's role while she watches (a "mirror" technique). The auxiliary egos, representing a greater variety of personality types, frequently demonstrate possibilities which the protagonist becomes quite eager to experiment with. It often proves insufficient to point out the existence of a masochistic pattern without giving the patient an emotional acquaintance with healthier alternatives in her present situation. Certainly the possibility of divorce could be explored, and future-projection scenes set up to investigate the experience of a post-divorce adjustment.

In conventional psychotherapy with women, it frequently happens that the transference relationship to a male therapist becomes either so intense that it can no longer be resolved by analysis or the patient remains emotionally aloof from the therapist thus hiding the masochistic or pity-seeking patterns that she lapses into in close relationships. The psychodrama techniques avert these difficulties. In the safety of her separate world on the stage she has all the excuse she needs to act out her characteristic neurotic patterns fully, yet even the most disturbed patients rarely develop unmanageable transference feeling towards the therapist or the other group members. When they step off the stage they return to their life role in the way a hero and a villain of a conventional play can have dinner together after the show.

In the period following a cathartic psychodramatic experience the patient is in an optimal state for the acquisition of insight. Her acting out needs have been fully indulged and yet the memory of her behavior is still fresh in her mind. In the general discussion after the dramatic phase of the session she can frequently gain greater distance from herself than at any other time. Frequently the meaning of what she has done becomes obvious to her so that little "analysis" is required by the group members or by the therapist. Since being analyzed or torn apart by the group members tends only to cater to her masochism the group is encouraged to emulate the patient's courage in exposing her neurotic patterns by acknowledging similar tendencies in themselves. By their identification with her they might be reminded of having used illness for special privilege or of their own inability to terminate unsatisfactory relationships.

It should be emphasized again that psychodrama differs from psychoanalytic methods in its flexibility of technique. Rather than simply waiting patiently for crucial material to float to the surface on free associations the psychodrama director is constantly improvising techniques and procedures appropriate to the moment. The suggestions of the slow approach through tangential material, the exploration of conflict by splitting the ego, the tracing of the masochistic pattern through scenes with husband, mother and stepmother, the acting out of alternatives and the employment of group empathy are only typical measures which might be used in such a case. Furthermore, the variety of ways in which the live patient might react to these techniques are nearly as unpredictable as human spontaneity itself.