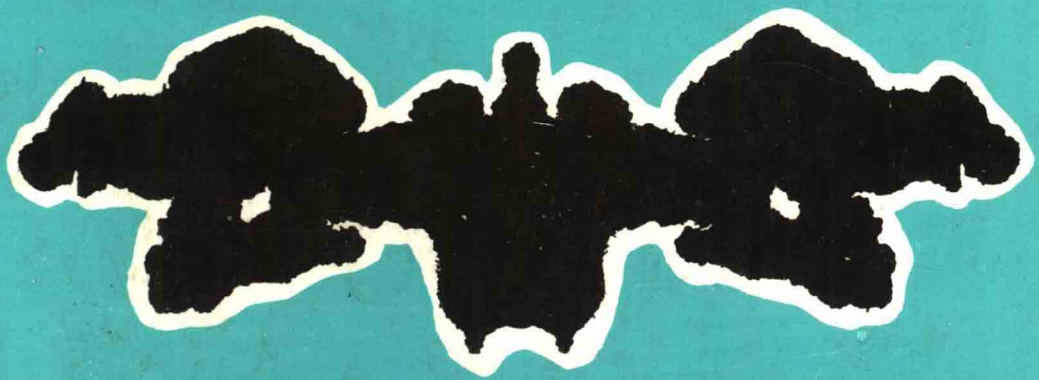
CASE STUDIES IN PSYCHOTHERAPY



DANNY WEDDING • RAYMOND J. CORSINI
EDITORS

CASE STUDIES IN PSYCHOTHERAPY

DANNY WEDDING
RAYMOND J. CORSINI
EDITORS

Printed in the United States.
F.E. Peacock Publishers, Inc., Itasca, IL
Library of Congress Catalog Card No. 88-061529
ISBN 0-087581-338-0
6 7 8 9 10 Printing
93 Year

FOREWORD

As a student, therapist, and researcher I have always felt that there is more to be learned from what psychotherapists do than what they say they do, and that psychotherapy must be studied on the basis of the transactions between a therapist and a patient rather than the theoretical formulations by which "systems of psychotherapy" are generally known. It is also true that compared to the plethora of theoretical writings in the clinical literature there is a striking dearth of case histories, particularly verbatim accounts. Prior to the advent of sound recordings, primary data were impossible to obtain and case histories of necessity had to be constructed from a therapist's notes and memory. Sound film, and more recently, videotape recordings have ushered in a new era in which for the first time it has become feasible to study in detail the actual interchanges between patients and therapists.

The lack of adequate technology,however, has been only one of the reasons for the relative dearth of primary data. Issues of confidentiality have always been real and our collective awareness of protecting a patient's identity has been significantly sharpened during recent years. However, there is reason to believe that therapists have been the more reluctant party. Carl Rogers, perhaps more than any other prominent therapist, deserves the credit for breaking with the tradition of secrecy, and many other experienced therapists have followed his lead. This is both a welcome and a necessary change because in order for students to learn they have to be in a position to study the masters, not residents or graduate students taking their first faltering steps. Until fairly recently, the situation was analogous to what might be the case if virtuosos like Heifetz, Stern, Szigeti and others had never performed in public and our knowledge of what expert violin playing is like had been restricted to listening to the scratching noises of novices.

As all therapists privately acknowledge, there is a vast hiatus between the printed exposition of a theory and its practical application. A theory, by definition, is an abstraction, and at times it has only a vague resemblance to clinical reality. In order to understand the ther-

apeutic process and how therapeutic change occurs, we must study *what goes on between a therapist and a patient.* There is an apocryphal story that Freud said many things to patients between the time they rose from the couch and left the office, and for all we know these seemingly casual comments, suggestions, recommendations, or whatever may have played as important, or more important, a part in their therapy than the formal interpretations Freud advanced when the patient was in a recumbent position. Yet Freud and all other theoretical writers chose to conceptualize their operations in particular terms, often leaving out of account elements that might have been of far greater significance than the operations to which therapeutic change was attributed by the theory. What needs to be understood about psychotherapy is what works and how it works, which is not necessarily the same thing as the theory. All a theory can ever be is an approximation.

However, even with verbatim accounts, sound tapes, or films, we still have a hard time divining the nature of the patient's *experience.* We cannot look into the patient; we do not know the *meanings* he or she attributes to the therapist's questions, comments, interpretations, gestures, smiles, frowns, hesitations, and so forth, nor can we adequately describe internal, structural changes that may occur. We are always dealing with an exceedingly complex process involving two (or more) people, and we can never go beyond inferences concerning the interactions. The dilemma is this: if we arrest the process, as one might in stopping a film, we destroy its living quality; if we immerse ourselves in the process we are left to struggle with multitudinous variables whose single effects we cannot isolate. We cannot observe how the grass grows; we can only discern that after a period of time *something* has happened that produced the change. A case history, therefore, no matter how detailed or perspicacious will still remain only a pale replica of the astounding richness of any human relationship.

In recent years a body of literature has concerned itself with the question of "specific" versus "nonspecific" factors in psychotherapy. The former set of variables pertains to the techniques purported to produce therapeutic change, the latter to such variables as the therapist's kindliness, warmth, empathy, understanding, respect, commitment, and so forth. The distinction is artificial: there is no such thing as a "nonspecific" factor—only factors we do not fully understand. It may well turn out to be the case that the weight of the therapeutic influence is carried by these so-called nonspecific factors, but they are clearly as much in need of specification as a technique which might be described by its originator as unique.

The collection of case histories assembled in this volume is an ex-

cellent cross-section of contemporary psychotherapy and its antecedents. All therapists and students of therapy can learn much from these exemplars. To be sure, psychotherapy, like any practical art, cannot be learned from a book, but the case histories included here can be of great help to the serious student. In studying these fascinating accounts, I would urge the reader to keep in mind such questions as the following:

How and to what extent did the patient change as a result of his or her psychotherapeutic experience? Was the change real and lasting?

To what qualities in the therapist's attitudes, demeanor, techniques, or charismatic qualities can the change be attributed?

Could another therapist, using different techniques and having different personality attributes, have produced comparable changes? Could you use the same approach and expect comparable results?

To what extent can a particular approach be used by another therapist who inevitably is a person whose style, personality attributes, values, and convictions differ from the therapist portrayed in the case history?

Can the case history be considered a faithful and valid account of what actually transpired? To what extent has the therapist edited or slanted the report? To what extent do the therapist's biases and theoretical predilections color the printed account?

Were the idiosyncrasies of the patient and the circumstances surrounding the therapy a significant factor in the change he or she experienced? Is it possible to generalize from a particular case history to other patients, therapists, and circumstances?

Are there common elements in the various case histories transcending their apparent diversity?

No conclusive answers to any of these questions will be forthcoming, but they will provide food for thought to the critical reader. It may also be well to remember that psychotherapy as practiced by many fine clinicians is often less dramatic but no less valuable on that account.

Hans H. Strupp
Vanderbilt University

PREFACE

We have been gratified by the positive response to the first edition of this book, titled *Great Cases in Psychotherapy.* Many professors have used it to supplement its companion volume, *Current Psychotherapies,* and a considerable number of students have read the book on their own because of its intrinsic interest.

Despite this success, we have been made aware of the limits of the first edition in illustrating specific techniques and methods employed by practitioners of various therapy systems. This was the original purpose of the book, balanced by our desire to include work by major historical figures and "breakthrough" cases whenever possible. Unfortunately, an undue amount of compromise was required to achieve this balance: too often the "great" cases were simply not good teaching cases or did not illustrate contemporary practice. Freud's Rat Man case, for example, was used to illustrate psychoanalysis in the first edition, and we still believe it should be required reading for every serious student of psychology or counseling. However, it simply did not illustrate the manner in which contemporary psychoanalysts practice therapy and so, in this new edition, we have replaced it with a better teaching case. We made similar decisions about cases by Jung, Adler, and Wolpe. To reflect this change in philosophy we have adopted a new title: *Case Studies in Psychotherapy.*

A new edition was also necessary in order to keep pace with the changes reflected in the two most recent revisions of *Current Psychotherapies.* Psychotherapy is a shifting, dynamic field and new therapies are constantly being developed, while some older systems fall into disfavor. We are determined to work hard to maintain the currency alluded to in the title, *Current Psychotherapies,* and hope to revise this reader after at least every other revision of the primary text.

We have systematically removed citations and references since for the purpose of this book they have little meaning. However, readers who may be interested in studying the systems in greater depth should examine the original sources, since almost all of these cases have been selected from already published articles.

In addition, and for the same reasons, we have excised parts of

manuscripts that we thought were not pertinent for those individuals who are using *Current Psychotherapies* as the accompanying text.

We hope our readers learn from these cases and find that they supplement the respective chapters in the larger text. But most of all we hope that you will share the pleasure and excitement we felt when first reading each of these selections.

Danny Wedding
University of Missouri
Columbia, Missouri

Raymond J. Corsini
Honolulu, Hawaii

CONTENTS

Foreword ix

Preface xiii

1. Working with a Borderline Patient 3
   L. Bryce Boyer
2. The Case of Roger 23
   Harold H. Mosak and Michael Maniacci
3. The Case of Werner 51
   Jolande Jacobi
4. The Case of Mrs. Oak 63
   Carl R. Rogers
5. A Twenty-Three-Year-Old Woman Guilty about Not Following Her Parents' Rules 87
   Albert Ellis
6. Lemon-Juice Therapy: The Control of Life-Threatening Rumination in a Six-Month-Old Infant 113
   Thomas Sajwaj, Julian Libet, and Stewart Agras
7. An Interview with a Depressed and Suicidal Patient 125
   Aaron T. Beck
8. The Case of Jane 145
   Frederick S. Perls
9. Black and Impotent: The Life of Mercedes 165
   Rollo May
10. A Terminated Case with Follow-Up 179
    Eric Berne
11. The Daughter Who Said No 195
    Peggy Papp
12. The Case of George 227
    Arnold A. Lazarus

Index 239

CASE STUDIES IN PSYCHOTHERAPY

EDITORS' INTRODUCTION

THE WORK OF L. Bryce Boyer with a borderline patient is the best example of contemporary psychoanalysis that we could locate after reviewing dozens of published case histories. This case demonstrates protracted treatment (over eight hundred sessions spanning seven and one-half years) and illustrates how a skilled therapist manages problems like personal vacations, sexual misbehavior in the therapy hour, and suicide attempts. We believe L. Bryce Boyer does a particularly good job of analyzing transference and countertransference.

This case history raises important issues, not the least of which is whether or not we as a society can afford to offer expensive treatment by highly skilled practitioners to patients with severe mental health problems. Psychoanalysis of the type illustrated here is perhaps the most expensive of therapies and the gains won by this woman were achieved at considerable personal and financial cost.

It may be useful for students to imagine how they would handle the therapeutic challenges presented by this most difficult patient and to contrast this treatment with that provided by Dr. Boyer. Most people working in the mental health field will eventually encounter a borderline patient like the one described in the following case.

CASE 1

Working with a Borderline Patient

L. BRYCE BOYER

Fifty-three years old when first seen, Mrs. X was a twice-divorced Caucasian, friendless, living alone and almost totally impulse-dominated. She looked and dressed like a teenage boy. She had been a chronic alcoholic for some twenty years and had been hospitalized repeatedly with a diagnosis of schizophrenia. She had been jailed many times, and while in the "drunk tank" had masturbated openly, smeared feces and screamed endlessly. She had lived dangerously, having on various occasions provoked sexual assault by gangs of black men in ghettos. In the last twenty years she had had many forms of psychiatric care (excluding shock therapies), but without effect. She had lived for about a year in a colony designed for faith healing, led by a guru. There appeared to be but two redeeming features when she was first seen: (a) She had concluded that her problems were based on unconscious conflicts and wanted an orthodox analysis. (Various respected analysts had refused her.) (b) Having been told by the most recent therapist of her psychotic son that her interactions with him kept him sick, she wanted very much to stop contributing to his illness.

Her forebears were wealthy aristocrats and included Protestant religious figures. The males all graduated from prestigious universities, and the females, products of noted finishing schools, were patrons of the arts. Her parents treated those who were not their social peers as subhumans. Her bond salesman father's chronic alcoholism resulted in the loss of his and his wife's fortunes during the patient's

L. B. Boyer (1977). Working with a borderline patient. *The Psychoanalytic Quarterly, 46,* 389-420.

late childhood. From then on her nuclear family lived on the largesse of relatives.

Her mother was highly self-centered and throughout the patient's childhood and adolescence remained in bed during the daytime for weeks on end, depressed, hypochondriacal, and unapproachable. She vacillated between two ego states. In one, she lay with her aching head covered by cold cloths, moaning and complaining about mistreatment by all, but particularly her husband. In the other, she lay in reveries, reading romantic novels. Much later in treatment the patient remembered that when her mother was in such a dreamy state, she permitted the child to lie with her and perhaps to fondle her mother's genitals, manually and with her face. The mother's withdrawals seemingly could be interrupted only by the temper tantrums of two of the sisters when parties were being planned for social lions or when she was planning to take the grand tour alone. She often left unannounced for her annual European jaunts but sometimes she would confide in the docile Mrs. X that she was leaving and swear her to secrecy, assigning her the task of tending the other children, who voiced their objections dramatically when they knew of their mother's impending departure.

The patient was the second of four sisters, born three years apart. All were reared by a senile woman who had been the mother's nursemaid. The oldest remains a frequently hospitalized alcoholic spinster. The younger two are vain, childless divorcees who live on generous alimony and who continue to have a succession of young lovers. All five females were contemptuous of the father, whom the mother divorced after the patient was married. Thereafter, the mother gave up her depression, hypochondriasis, and withdrawal and became a spirited woman. She had platonic affairs with young male authors whom she sponsored. The father married a warm woman, became abstinent, and returned to work. After many years, he regressed to serious depression and committed suicide by throwing himself in front of a train. This was one year before the patient first saw me. She had had no contact with him since his remarriage and thought of him only with contempt. When she heard of his death and burial, she felt totally detached. At the beginning of therapy, she indiscriminately idealized her mother and devalued her father.

When she was less than three years old, an incident occurred on board an ocean liner. Something happened in a stateroom which frightened the child so that she fled crying to her mother, who was breakfasting with the ship's captain. Her mother ignored her anguish, but a black waiter comforted her, holding her and giving her a cube of sugar. The patient explained to me that she felt the outcome of her

treatment hinged on the recall of that memory and on my capacity to accept what she had to tell me without disgust, anger or anxiety.

Before attending school she was an avid reader of fairy tales, and in her first year she did well. But during the second, she became incapable of learning. She read unwillingly and with great difficulty and was unable to learn the simplest mathematics. She never passed a single test during her grammar or finishing school years. This was unimportant to her parents; they taught her that her obligation to the family was to be charming, to exploit her beauty and wit, and to get a rich doctor as a husband who would support the family.

During the second year of schooling she became sexually involved with a swarthy chauffeur who wore black gloves, but she did not reveal their frightening activities, believing that risking death was somehow in the service of her sisters' getting parental love.

During her latency period, she was exceedingly docile and well-behaved. She had a severe obsessive-compulsive neurosis and believed that her family's lives depended on her thoughts and actions. She was a religious martyr who projected onto her parents the wish that she die so that her sisters would be the recipients of all her parents' love. In this way the sisters would become less disturbed.

When she was eleven she was sent away from home for the first time to attend a finishing school. She soon lost her previous nighttime terrors of attack by something vague and unvisualized, and gave up her endless nocturnal rituals. While there, she became enamored of a popular girl who seemed perfect, although she knew of her hypocrisies and manipulations. She was content to be one of an adoring coterie of this popular girl so long as the girl's attentions were equally divided among her worshippers. When the patient was sixteen, however, her idol became enamored of another girl and the patient went into a catatonic-like state. She was sent home from school, and for the next five years she remained passive, felt mechanical, and went through the motions of living.

She never had any boyfriends and was awkward at parties. She wistfully reveled in her mother's attractiveness as a hostess and vaguely wished that she would someday be her mother's social equal.

While she was in her teens, her father, an outcast at home, spent much time boating. The patient, in her role of family protector, willingly went with him, taking the helm while he got drunk in the cabin. She believed her parents wanted her dead and that she should be killed. She went with her father not only to look after him but to make it easy for him to murder her for the good of her sisters.

When her older sister was able to get a rich medical student to propose marriage, the patient was galvanized into activity and got him to choose her instead. Once married, she was sexually passive and anes-

thetic. On their honeymoon her husband became so infuriated by her sexual passivity that he sought to murder her, being thwarted only by chance. She felt no resentment and never told anyone, thinking his act had been further evidence of the validity of her being destined to be the savior-martyr.

She lived with his parents in one city while he continued medical school in another. He sent her occasional letters in which he depicted his affairs with sensual women. She was vaguely disappointed. His senile father, a retired minister, considered her passivity to be the result of her having been possessed and sought to exorcise her by giving her enemas while she was nude in the bathtub. This was condoned by her mother and her husband. She felt neither anger nor excitement. She wondered at times if he were getting some sexual or sadistic pleasure from his actions and fantasized seducing him or committing suicide in order to humiliate him by exposing him—all for the good of others.

Following his graduation, her husband joined the military and they moved to another part of the country, whence he was shipped abroad. She was utterly without friends or acquaintances. His letters were rare and included accounts of his affairs with uninhibited women. She bore him a defective daughter and could not believe she was a mother. She feared touching the baby, leaving her care to maids. She felt the baby's defect to be her fault which was somehow associated with her actions with the chauffeur. She began to drink in secret. On leave, her husband impregnated her and she bore another daughter who again she could not believe was hers and whom she could not touch. She began to frequent bars and to pick up men to whose sexual demands of any nature she would submit, always with total subsequent amnesia. She learned of her actions by having them told to her by the children's nurses. Then she bore a defective son who became an autistic psychotic. She was totally helpless in the face of his unbridled hyperactivity and feces-smearing. He was hospitalized after about a year and remained so until his early adolescence, rarely acknowledging her existence in any way. Her husband divorced her, her daughters were sent away to institutions, and she lived alone.

For twelve years and periodically later her life was occupied with bar activities and sexual encounters for which she continued to have amnesia. She would pick up black men and submit to their manifold sexual abuses. She passively assented and at times encouraged them to take her money and jewelry. One of her many therapists suggested that she would feel less worthless if she were to prepare herself for some occupation and stop living on what amounted to charity. She managed to complete a practical nursing course and then worked in various psychiatric hospitals where she felt she was of some use because she could understandingly care for psychotic and senile pa-

tients. She was fired from a number of such positions for being absent and for appearing on the job while intoxicated or hung over.

In one of the hospitals where she worked, she met a male patient who was her physical counterpart, even to the color of her hair and eyes. They were so alike she wore his clothes. He was addicted to various drugs, including alcohol, and totally dependent on his family and welfare. She soon began to live with him. She adored him as she had her mother and the girlfriend of teenage years. She knew of his many faults but totally idealized him. She felt complete and rapturous with him and at times believed they were psychological and even physical continua. They were married, and the idyllic fusion persisted. Periodically, they bought whiskey and went to bed where they remained for days, engaging in polymorphous sexuality to the point of exhaustion, occasionally lying in their excreta. While she never had an orgasm, she felt complete. Such episodes were especially pleasant to her when she was menstruating and she and her partner were smeared with blood, which she sometimes enjoyed eating. After some nine years of marriage, he divorced her for reasons which she never understood, particularly since she supported him financially. Then she became a mechanical person once again and resumed her pursuit of men in bars.

A year before treatment began, she obtained an undemanding job as a file clerk where her superiors tolerated her lateness and incompetency. She lived on her meager salary and placed no value on material possessions. She believed that she had never had a hostile wish and that throughout her life she had invariably sought to help others.

Course of Treatment

Over the years, I have gradually come to accept for treatment almost solely patients whose activities are apt to influence the lives of others, such as educators, physicians, and professionals who work in the mental health field. Yet it did not occur to me to refuse her request to try psychoanalytic treatment. I found appealing her determination to undergo for predominantly altruistic purposes a procedure which she well knew would be painful. And I felt comfortable with her.

She was seen at what she knew to be reduced rates three times weekly on the couch for about five years, payments being made from a small endowment from a deceased family friend. After a trial six-month interruption she resumed treatment on the couch twice a week for two more years, making a total of over eight hundred interviews in seven and a half years.

Before analysis is undertaken with such patients, I tell them that our work is to be cooperative and of an experimental nature and that

we cannot expect to set a time limit; that they are to make a sincere effort to relate aloud whatever comes to their minds during the interviews and to report their emotional states and physical sensations; that I do not send statements and expect to be paid what is owed on the last interview of the month; that they will be charged for cancellations unless their scheduled interviews are filled by another patient; and that I am away frequently for short periods and one long period during the course of each year and will inform them of the expected dates of absence as soon as I know of them. When an occasional patient inquires what is to be expected of me, I state that I shall keep the scheduled interviews and be on time; that I do not give advice unless I deem it necessary; that I see my role as seeking to understand as much as I can about the patients and will tell them what I have learned when I consider them ready. I explain that I expect to be wrong at times and that the final validation will depend on the patient's responses and memories. For these patients I have found such specific conditions offer needed ego and superego support.

As is common with patients with borderline personality disorders, during the first two structured interviews, Mrs. X's productions were but slightly tinged with primary process thinking. However, there was a periodic affective disparity which confused me; I was undecided whether it constituted *la belle indifférence* or schizophrenic dissociation.

During her third interview she eagerly lay on the couch, her speech promptly became heavily influenced by primary process thinking and she was at times incoherent. Her verbal productions were highly symbolic and her language was often unusually vulgar. She made tangential references to fairy tales, fusing elements of *Beauty and the Beast*, *Cinderella*, *Hansel and Gretel* and *Snow White*, and told a story which involved a good witch who transported children through a magical opening into a paradise in which the protagonists fused and became perpetually indistinguishable and parasitic, needing no others for their constant bliss. She also alluded to a white elephant and a spider.

She did not seem frightened by her productions or her style of presentation. There was some embarrassment about her foul language but her principal reaction was one of mild curiosity as to why she talked so strangely. My own reaction to her behavior was one of mild surprise at the degree of such prompt regression, of empathy with her embarrassment, and of detached intellectual curiosity.

I felt at ease with this patient. As a result of idiosyncratic childhood experiences, I have long comprehended unconscious meanings of primary process thinking and have been able to use its contents in synthetic manners. I have also devoted many years to the study of