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The difficult patient in combined therapy: A case study[#]

PETER PRAPER[*]
University of Ljubljana, Department of Psychology, Ljubljana, Slovenia

Abstract: After the shift of the psychotherapeutic treatments towards the patients with ego-deficits and severe pathology, combined therapy is considered to be one of most important innovations of the last decade; at least in the USA, while Europe is still hesitating to explore this possibility. The term Combined therapy indicates individual (mostly developmental analytic) and group (mostly group-analytic) psychotherapy, led by the same therapist. The presented case study includes the carefully examined therapeutic process of a severe shizoid patient. The process was controlled by constant supervision, including both the patient's changes and reactions of the group, the transference and countertransference phenomena, advantages and difficulties, as well as the outcome.

Key words: ego-pathology, psychotherapy, combined therapy, case study

Pacientka s težko patologijo v kombinirani terapiji: študij primera

PETER PRAPER
Univerza v Ljubljani, Oddelek za psihologijo, Ljubljana

Povzetek: Kombinirana terapija je oznaka za hkratno terapijo nekega pacienta/klienta pri istem terapevtu v diadni modalnosti in v skupinski analizi. V Evropi je to relativna novost, v ZDA pa je kombinirana terapija dobila svoje mesto kot samostojna modalnost, ki se praviloma uporablja za obravnavo pacientov s težko patologijo in mejno organizacijo osebnosti. Predstavljen je primer hudo shizoidne pacientke, ki je bila sprejeta v diadno razvojno analitično psihoterapijo, v tretjem letu obravnave. Vse do šestega leta je bila vključena tudi v skupinsko analizo in v tem obdobju je izpeljala separacijski proces v individualni terapiji, nakar je v sedmem letu obravnave zaključila z opaženim uspehom tudi skupinsko terapijo. Primer je v Evropskem merilu, še posebej pa doma, predstavljal inovacijo, ki je potrdila pričakovanja, grajena na teoretičnih predpostavkah. V delu so skrbno spremljani vzporedni fenomeni pri pacientki in pri skupini, vključno z vprašanji indikacij ter kontraindikacij, selekcijo pacientov, transfernimi in

[#]*Sedem let trajajoča študija primera in skupinskih fenomenov v modalnosti kombinirane terapije je bila predstavljena na četrtem evropskem simpoziju na temoThe "difficult Patient and Group Analysis" v Atenah.*

[*]*Naslov / address: izr. prof. dr. Peter Praper, Univerza v Ljubljani, Oddelek za psihologijo, Aškerčeva 2, 1000 Ljubljana, Slovenija, e-mail: peter.praper@guest.arnes.si*

kontratransfernimi vprašanji in vidiki razvojnih procesov pacientke in celotne skupine.

Ključne besede: huda patologija, psihoterapija mejnih primerov, kombinirana terapija, študija primera

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Let me begin with the experiential part. That was the way I came in touch with the modality of a combined therapy (Praper, 1997).

Yana, a female patient with a rather schizoid personality structure, was referred for individual analytically oriented psychotherapy after having received occasional psychiatric treatment for six years without any improvement and more than that: After her immediate moving from home into a new flat, she found herself in a near psychotic crisis. Disintegrated, disoriented and suicidal, Yana had been accepted in analytical, developmentally oriented psychotherapy, focused on the process of separation and individuation. After two years (having one session weekly) she found herself at the cut off point of triangulation. Her search for siblings and primitive Oedipal situations coincided with the therapist's own change - his transition to the university and reduction of clinical work. The idea was to include Yana into an analytic group. During the period of individual treatment the first year was needed to establish a kind of a symbiotic relationship. At the beginning, Yana was not even capable of establishing eye-contact, but she was able to verbalise her fears of being swallowed into dependency and her mistrust thus supporting the development of therapeutic alliance.

Yana's ego deficits appeared to be connected with her phase-specific traumas. During the period of her 9th month to 2nd year she was put in plaster, having had a luxation of the hip. Both the process of practising, as well as her self-experience, were severely damaged. She continued to experience herself as an incapable, bad and invalid person. Having been hospitalised several times, her way out of dyadic, symbiotic relationships must have been altered. Later it became obvious that her mother's punitive and penetrative attitude had also played an important role in Yana's development.

What was most important during the first year of individual treatment, was "to be with the patient" as Balint used to say, to assure the object - constancy or in other words the therapist's constancy (to be there punctually at the certain day and hour, in the same room...). Entering the second year of treatment, Yana showed an interest for contacts with her two brothers and with a few old (female) friends. In addition she started working through the memories of her idealised and distant father who died when she was 18, at the same time settling accounts with her mother. This course was leading her towards examining her own position in the family, her group of origin. My expectations that the transition from individual setting to group treat-

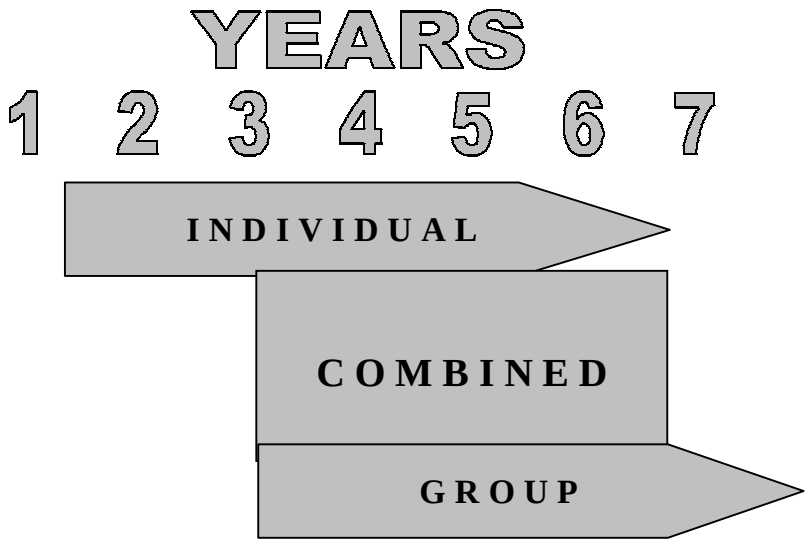

Figure 1: The dinamics of the therapy during seven years.

ment may last no more than 2-3 months, were found too optimistic. Though on the doorstep of triangulation, Yana was not ready for the separation. I decided to leave the timing to the patient's developmental process, carefully supporting the individuation, step by step, subphase by subphase. So we entered the period of *combined therapy* which was less the fruit of my knowledge than the consequence of my naive expectations.

The modality of combined therapy

Combined therapy is, by definition, a concurrent individual and group therapy conducted by the same therapist. It differs from conjoint therapy, a treatment with two different therapists. Hobdell (1991) holds that the first reference to combined therapy was by Foulkes (1944). He was not in favour of combined therapy at that time though later he experimented in this field together with Harold Kaye, an American, but their joint venture had remained practically unknown. So the British School and Europe had missed the opportunity and the idea was took over by the group therapists from USA. The possibilities of combined modality were examined so intensively that as early as during the fifties and sixties over 50 contributions dealing combined therapy appeared, while lately this once controversial modality was accepted as a part of the mental health scene.

The decision for combined modality was mostly made on clinical grounds, arising out of necessity after the shift towards borderline and narcissistic patients. Wong (1988) holds that combined therapy may be the most effective therapy for the majority of borderline and narcissistic patients. While a dyadic setting may facilitate the initial restoration of an emphatic alliance, and again the resolution of termination phenomena and working through separation, it also has its limits. When patients with severe pathology are in question, the individual treatment may easily become interminable.

Group analytic treatment may result in better working through of otherwise refractory resistances (Graham, 1984). The basic difference lies in the nature of the relationship, dyadic in individual and triadic in group setting, not to forget that from the developmental point of view we are passing through the dyade to reach the point of the individuation and then to be ready for creative interrelations in the group. Probably that is the reason why it is almost universal practice among therapists employing combined therapy to initiate treatment with a period of individual therapy and to add group therapy at a later point, once the patient works the way out of maternal dyadic - symbiotic patterns of object relations, experiencing the need to proceed to sibling relationships. According to Cohn (1986), British group analyst who succeeded to explore the possibilities of combined therapy, not anything can be combined with anything. I completely agree with his proposition to combine analytically (developmentally) oriented psychotherapy (not more than twice a week) with once weekly group analysis of Foulkesian kind. Once establishing it, we may join Schlachet (1990) who believes that we are facing a new modality, an integrated whole and not the combination of two modalities. The idea is that they are two sides of the same coin.

There are, of course some problem areas in combined therapy. Among the most frequently mentioned is the problem of confidentiality. The beliefs range from those who propose avoidance of bringing material from the individual into the group setting, to those who demand that the patient or even therapist make the material of individual session known to other members of the group. The best solution is to leave it to the patient to decide what to bring into group, while any important content may be the subject of analysis in each modality. The same happens to other problems such as the interplay of vertical (parental) and horizontal (sibling) transferences, with the affects of envy, jealousy and rivalry involved, what may well support the differentiation and the emergence of the sense of interdependency.

Now, going back to Yana and the group. After joining the group she started practising under broadened conditions: directly “here and now” in the group, using individual treatment as a rapprochement situation. In her everyday life she decided to change the flat. To wait for the new one, she returned home for a period of more than a year. This was the opportunity to practice directly in the family of origin, to restore the mistakes of the first, unsuccessful separation. When it seemed that she had suc-

ceeded, she started with separation plans in individual therapy but was not able to terminate without entering a process of mourning, lasting for another year. The dual setting enabled her to continue analysis in the group and at the same time to continue the mourning process with the therapist. The transition from the schizoid-paranoid position to depressive position, in which her first tears were released, progression in practising, where her first interests emerged, and now and then a regression because of separation anxiety, demanded a long period of time and a lot of therapist's trust in the patient's potential.

During the first year of combined therapy, Yana made a splitting: her therapist (and individual therapy) was seen as being all good, while the group and the family of origin were all bad. Dyadic relationships in the individual setting were experienced as supportive, while group relationships were felt as intrusive. During the second year in the individual setting her transference contents with parental figures - idealised father and always responsible and guilty mother - came into the focus, while in the group her sibling transference with her brothers emerged. Yana went through malignant mirroring, through offering herself for a scapegoat and persecuting others, finally in the third year to become able to turn her anger toward the therapist, who was felt - during the termination phase of individual therapy - like rejecting her. There is no doubt that Yana's combined therapy had an important influence upon the group as a whole. It provoked many regressive reactions in other members, a lot of envy and rivalry and, as a reaction, many contradependent manoeuvres. I was struggling to make these the subject of analysis. After Yana's terminating the individual therapy the group as a whole entered the last year. There is no doubt that Yana's experience of terminating in individual setting, including the mourning process, helped her, as well as the group to survive the separation along terminating the group as a whole. Her dreams about the voyage in the bowels of a boat, approaching an end, about her fear of going out, but also her curiosity about the new country, became representative for every member of the group on the doorstep of his or her own voyage.

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