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Effectiveness of integrative mixed psychotherapy on Anaclitic-Introjective Depression

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Abstract

In this case study, the two year-long psychotherapy of a dysthymic and self-critical woman is presented. Her depression was conceptualized as a “mixed” anaclitic-introjective type according to the model of Sidney Blatt. Given the patient’s potentially destructive nature of depression and self-criticism, the therapist systematically applied an integrative mixed therapy, combining cognitive, behavioural and psychodynamic approaches. Based on DSM-IV-TR, changes in the patient’s functioning were assessed at the beginning and at the end of treatment via MCM-I-II. At post test, patient showed significant improvements in anaclitic-introjective depression, some dimensions of personality, as well as her adaptive functioning.

Keywords: Self-criticism; dysthymia; psychodynamic psychotherapy; mixed psychotherapy.

1. Theoretical and Research Basis

“The psychodynamic / cognitive developmental model of Sidney J. Blatt proposes that personality development in mixed depression psychopathology results from characteristic interactions with primary caretakers linked with rejection, deprivation, and unpredictable parenting. Under these circumstances the child becomes intensely preoccupied with attempts at establishing and maintaining relationships with caregivers to the exclusion of the development of the self. Being subjected to this punitive, controlling parenting style, the developing child may make exaggerated efforts at establishing self-esteem and independence, often to the exclusion of interpersonal relationships”. (Blatt & Homann, in 1992 quoted by Layne, Porcerelli & Shahar 2006).

Blatt (1974) has likewise distinguished between two subtypes of depression. Whereas anaclitic depression refers to excessive concerns about relationships, dependency, feelings of loneliness, and abandonment, introjective depression points to concerns about self-worth, achievement, and self-definition. Some patients present both types of concerns, known as “mixed” anaclitic-introjective (Shahar, Blatt, & Ford 2003).
Integrative mixed Psychotherapy is a systematic combination of cognitive, behavioural and psychodynamic interventions. In the first phase of treatment process, the therapist clarifies the patient's chief complaint in the most behaviourally defined manner; this is then followed by exploring her neurotic style that maintains and exacerbates patient's clinical symptoms. Consequently patient experiences the feelings she tends to avoid, independent of time, place, and person. At this stage, the therapist's function is direct and provision of treatment is well structured. Since the exploration process is implemented with no force and along with the patient, a sense of ownership is developed by the patient over the findings (Abedin, 2008; Young, 1999). In this phase a number of tasks are accomplished; they include: a) analyzing the cognition and behaviours ostensibly inseparable parts of patient's being; b) confronting maladaptive defences resulting in anxiety; c) exploring early maladaptive schema (Young, 1999).

In the second phase, during the psychodynamic process, the therapist provides a safe "holding environment" (Winnicott, 1965) in which through utilization of techniques such as clarification, patient is assisted to recognize her expressed emotions. Through confrontations, her attention is called upon the similarities and differences in the body of material and repetitive maladaptive behavioural patterns exposed in the sessions. Finally patient is helped via interpretation to become consciously aware of certain elements of her mental life; when properly executed, interpretations connect the actual life situations with past experiences and transference take place (Chesik, 1991, quoted by Bishop & Celin, 2003).

Free associations and interpretation of defences release the buried feelings. Making links between the transference issues and significant people in the patient’s current and past lives elucidate hidden conflicts more consciously; hence making intolerable experiences more acceptable (Davanloo, 1992).

In psychodynamic psychotherapy, a nurturing and supportive environment is provided and the punitive aspects of psyche are removed by modulating the superego. This will be achieved through understanding patient's needs and capabilities, and accepting the integrity of the connecting aspects of her past and present commonly known as the "child within" (Shahar & Blatt, 2004). Further reviewing and analyzing patient's past and childhood experiences are in order. The process entails encouraging the patient to remember the past and to imagine herself in her childhood and seeing the child's environment from her perspective. This provides a sense of understanding, reconnecting, and often “making up” with a child that had been ignored or even rejected for some time. The patients themselves, it should be recognized, often abandon and dissociate themselves from their own selves.

That proverbial “child within” reminisces feelings of rejection and abandonment obtained through introjections in her harsh childhood environment in which she was born and raised. She is further betrayed by the adult patients themselves as the child is associated with such undesirable feelings. This very child is resurrected by such techniques as letter writing, creating collages, and holding dialogs. This sort of conversation and reconnecting with the dissociated self (Fairbairn, 1994) in a protecting supportive and integrating manner resembles a parenting function. Through this process and with modelling of “good enough mother” (Winnicott,1960) attitude of the therapist, the patient learns to parent herself hence recognizing her needs, resolving conflicts, processing anxiety, and ultimately working through her issues (Abedin, 2008)

2. Case Presentation

Ms. A is a 30-year Old Iranian woman with the chief complaints of depression and relationship problems. She lacked motivation, and stated dissatisfaction, self-criticism and difficulty in relationships. Cognitive interventions were used primarily to draw attention to the irrational nature of Ms. A’s intense self criticism and self devaluations; psychodynamic interpretations were eventually applied to link her irrational beliefs to her inappropriate current behavioural patterns and childhood experiences. It was hypothesized that therapeutic process would address Ms. A’s introjective needs such as security, stability, love, acceptance, and self esteem. Furthermore development of a positive and stable therapeutic alliance would address her anaclitic needs.
3. History

Ms. A lives with her family; holding a Bachelor’s degree in Management, she has successfully maintained employment for the past six years. She is the fourth of five children in a family from upper middle socioeconomic strata. She described her father as strict and diligent, and her mother as kind and devoted. At home, she "got away with not studying" by providing services for others to escape punishment. This strategy was not effective on her father as his restricted attitude would only appreciate efficiency in school grades and for that he often humiliated his daughter.

Ms. A reported to receiving severe physical punishment by her father and "absolute" negligence by her mother due to her fears and weaknesses. Her social relationships before entering university were limited due to guilt, fear of punishment, and losing parental trust. In university, she seemed immature and disorderly due to lack of social skills, fear of rejection, and a constant sense of worthlessness. Her relations were afflicted with unreciprocated provision of services, anger, and desperation. Since two years prior to the commencement of treatment, she had been dating a married man.

4. Presenting Complaints

Ms. A stated hopelessness regarding management of everyday life stressors. She felt that she could not demonstrate adequate patience with her co-workers. In addition, she reported to lack of satisfaction with her education and felt that she is not able to ever achieve her career potentials. She described feeling of guilt much of the time and noted that she often experienced tachycardia under stress. She reported there were times that she wanted to fall sleep and not be awaken ever again. Her depressed mood had persisted for two years and she doubted if anyone could help her. She complained of not being able to express disappointment in her relationships fearing she would be abandoned. She described her life as an unbreakable cage.

5. Assessment

At intake, based on Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2004), Ms. A met the criteria for dysthymia on Axis I and dependent personality features on Axis II. With regard to interpersonal relationships, Ms. A lacked close female friends and often had tumultuous relationships with both male and female co-workers. She was emotionally dependent on her married boyfriend, who was emotionally unavailable, abusive, and unsupportive.

In Millon Clinical Multiaxial Inventory - II (MCMI-II) prior to treatment, the following peaks were evident: general and self-destructive factors, avoidance and dependency in Clinical character pattern ranks, schizotypal axis in personality pathology, Dysthymia in clinical syndromes and major depression in Acute Clinical Syndromes. The result validated the diagnosis and was the basis for the assessment.

6. Course of Treatment and Assessment of Progress

According to Ms. A’s initial mixed diagnosis, the therapist and her supervisor felt that interpretations should, whenever possible, include confrontation of her self-criticism on one hand and acknowledgement of her strengths on the other. She agreed to participating in the 45-minutes therapy sessions once a week.

The early phase of Ms. A’s treatment was characterized by low emotional level or gloominess, subjective feelings of failure, worthlessness, a pervasive disavowal of her needs for mutual interpersonal relatedness, and dissatisfaction of her current relationship. Specifically Ms. A’s self critical attitudes and guilt was not worthy. The main topics of the first few sessions were her attempts in seeking other’s contentment at the price of sacrificing her own needs and feelings, and her being constantly tired and desperate as a result of her ineffective efforts. Initially, the use of denial kept her from examining the extent of her relational difficulties, as shown in the following script.

Therapist: I wonder if you worry that I, too, might criticize you?
Ms. A: I worry that you’d think I’m loose.
Therapist: This is a dominant feeling you experience.
Ms. A: I know, I know. That’s just how I think.

The early interventions and explorations in the following sessions for the most part were met with resistance. Yet she was eventually convinced as how she ignored her needs usually for the sake of others’ desires. When her expectations are not complied by others, she represses her anger at the fear of further rejection and crawls into a corner with pain in order to forget or justify what she felt. This is an inefficient and dysfunctional mechanism that could not keep her away from experiencing anxiety anymore as she is often left dissatisfied in her relationships and moreover constantly worried about being abandoned.

Ms. A: I’m tired of repeating what I want to say in my head, I’m tired of being scared all the time, as far as I remember fear of upsetting others was with me; I get anxious when someone get upset.
Therapist: What exactly makes you anxious?
Ms. A: I don’t know…maybe I fear that they change their relationship with me or even worst, they would not want it anymore!

During the second phase of treatment (2nd - 5th months), client was able to connect people, incidents, and various parts of her past and present experiences with more understanding and insight. Using free association related to her childhood, she explored and worked through the relevant issues.

Therapist: It seems that you don’t feel comfortable in groups.
Ms. A: (Silence) it was my cousin’s birthday, I think I was six or seven, feeling humble...Feeling awful. (Silence)
Therapist: what does this little girl look like?
Ms. A: A pale violet shirt, short hair, crumpled, closed fists, looking at her luxurious cousin, nobody is looking at her.
Therapist: Anybody noticed her?
Ms. A: No, Not at all! But someone should have! Right? Someone should have felt what she was feeling.

Between the sixth and eighteenth month of treatment, patient realized how this child accepted her father’s extreme expectations by remaining silent, not participating in games with other children, and not interacting with school mates, and finally by devaluing all entertaining and athletic activities. She suppressed all her natural needs in order to gain his father’s confirmation and to prevent his anger, even though she never succeeded at this due to her unsuccessful academic performance.

This type of relationship pattern which later was resuscitated in most of her relations with others lead to repression of her needs and extreme compliance with others desires. Consequently in this manner, she received little care and intimacy reciprocated which in turn often had extreme anger ensued in her. When her expectations are not fulfilled, her initial beliefs such as being unloved and unwanted are validated. Needless to say, this process mostly occurs in unconsciousness aimed at disappointing others.

At this stage of treatment Ms. A began to encourage herself when she noticed her abilities and took her needs and insights more seriously. She ended the destructive relationship with the married man in which she had remained due to fear of loneliness. By ending this relationship, she started feeling worthy and demonstrated an improved capacity to tolerate perceived shortcomings and positive aspects of herself as well as those of others. Processing the notion of transference and making connections between now and the past enabled her to overcome the feeling of self degradation stemming from tumultuous past relationships. She then was able to enter into termination phase of treatment and expressed sorrow over the days lost in her life and started planning her future life.

Ms. A: I have some news for you; I got accepted to continue my education. I feel this is the first time I study for myself, I don’t know how I passed all these years, but I am glad that my future life is mine.

At the end of therapy, Ms. A no longer met criteria for dysthymia, and she could use her energy to study and establish satisfactory interpersonal relationships. She also joined a mountain climbing club.
In the post test MCMI-II, there was a drop in all traits standing mostly below neurotic line. This indicates more stable personality, change of character pattern from a dependant avoidant personality with self-defeating attitude (8B /2/3) to a more efficient, disciplined, and assertive person (7/2/6B).

Salient decrease in scores such as 8B , 2.2. S, D,cc and increase in 5 and 6B scales indicated enhanced capability in anger management and self satisfaction.

At the end of treatment all these changes resulted in higher capacity to accept herself as well as others. More mutual understanding of emotions in social and interpersonal interactions in Ms. A was obtained. These changes lead to enhancement of self-respect in her.

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