

Innovative Interventions in Psychotherapy

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Foreword

New approaches to psychotherapy and specific techniques associated with these approaches have proliferated during the past several decades, and more continue to be proposed. Thus, for example, dialectical therapy, emotional transformation therapy, energy psychology, synergistic therapy, healing from the body up, imago relationship, sacred therapy, core energetics, humanistic therapy, as well as the more traditional methods, are only some of the psychotherapeutic approaches referred to in a single recent issue of a clinical journal.

As a result of these developments, there has been a movement in the direction of greater flexibility with regard to psychotherapeutic treatment. The notion that only one form of psychotherapy is worthy of the name, or is the treatment of choice for all psychological difficulties, is no longer generally accepted. Serious attempts have also been made to gain further understanding of the relative effectiveness of various interventions in the treatment of different kinds of problems. Moreover, the need to adapt the treatment to the patient rather than the reverse has, at least in theory, gained greater recognition. Nevertheless, although mental health practitioners may now choose from a wide variety of general methods and specific techniques that have achieved a measure of professional acceptance, too often they remain faithful to a single approach, not infrequently waxing overly enthusiastic in their descriptions of the therapeutic successes resulting from the use of this approach and paying considerably less attention to failures.

By way of contrast, the case reports in the present volume are descriptions of the many different therapeutic interventions used by the authors in dealing with a wide variety of problems presented by adults, children and families, individuals and groups. The flexibility, sensitivity, originality and creativity reflected in these treatment reports, the matching of the appropriate approach or combinations of approaches and

techniques to the different problems at hand and to the person or persons in question, and even the matching of the type of therapeutic relationship to the personality of the patient or patients involved, are noteworthy and extremely impressive.

Therapeutic flexibility unfortunately may, at times, be synonymous with catch as catch can looseness. However, in the cases described here, treatment choices are based on very careful, creative consideration of all of the issues at hand, including the personality of the patient or patients, cultural background, as well as the difficulties presented. Moreover, in no instance is the approach to treatment based on dogma or inappropriate faithfulness to a particular method of intervention.

In addition to the fascinating descriptions of different kinds of psychotherapeutic treatment, this volume also includes thoughtful and enlightening discussions of a number of subjects not frequently broached in writings on psychotherapy. These include the question of mobility in the treatment room, as well as the complex and extremely sensitive issue of types of touching in treatment that may in certain specific instances be therapeutic, and the potential usefulness of clerical intervention with certain patients.

The present volume unquestionably constitutes a significant contribution to the clinical literature. The case reports, with their descriptions of many types of therapeutic interventions and combinations of interventions in dealing with a wide variety of difficulties presented by different patients and patient groups, as well as the discussions of important topics in psychotherapy, add to our knowledge of the many facets of psychotherapy, enrich our understanding of the treatment process, and deepen our appreciation of the importance of therapeutic sensitivity and flexibility.

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Preface

This book describes a variety of innovative interventions, approaches and models that the authors have developed and applied in their clinical work over the last several decades, with children and adults with a variety of disorders in different formats.

Two characteristics that reflect the treatment approaches presented are flexibility and creativity which we believe are essential, (in addition to empathy), for successful psychotherapy. The therapist par-excellence that demonstrated these traits in the treatment room was Milton Erickson, the "Einstein of treatment". (Haley, 1986) Erickson believed that, "Each person is a unique individual. Hence, psychotherapy should be formulated to meet the uniqueness of the individual's needs, rather than tailoring the person to fit the Procrustean bed of a hypothetical theory of human behavior". (Zeig and Lankton, 1988) Or as Maslow cautioned: "If the only tool you have is a hammer, you will treat everything as if it was a nail". (Maslow, 1966)

A therapist must have the knowledge and be able and willing to integrate and apply components of various theories and approaches in a thoughtful and practical manner. (Dimond, et. al., 1978) No less important than "techniques of choice" are "relationships of choice" for effective therapy. "A flexible repertoire of relationship styles, plus a wide range of pertinent techniques seem to enhance treatment outcome. Decisions regarding different relationship stances include when and how to be directive, supportive, reflective, cold, warm, tepid, formal or informal. If the therapist's style differs markedly from the patient's expectations, positive results are unlikely". (Lazarus, 1993)

Flexibility should also be demonstrated in regards to the length of the sessions, time between sessions, treatment, and involvement of significant others in the session, as well as colleagues from different disciplines and orientations, when indicated.

Flexibility in perceiving and evaluating things and situations is a sine qua non for creative thinking. To be a creative therapist requires originality and unconventionality in one's thinking and one's actions and the willingness to take risks. Quaytman, (1974) concluded, "...what makes a creative psychotherapist is the extent to which she can risk chance, utilize diverse approaches to therapy, avoid dogma which denies a person's uniqueness, and expand her own life experience."

It is also essential that there be a focus to the treatment in order that there will be clarity about goals and, therefore, how to reach the desired outcome. The therapeutic process can be expedited by assigning "homework" between sessions, which may include having the client do specific tasks and exercises, think about a certain issue, possible change in his views and/or behavior, etc. Budman's "time-effective therapy" (Shay and Wheelis, 2000), Carlson's "client-focused integrative psychotherapy", (1999) Cummings's "Focused Psychotherapy", (1995), and Omer's strategic approach (1994), are compatible to the way we think and work in therapy.

"In the beginner's mind there are many possibilities, in the expert's mind there are few". (Suzuki, 1972) Though we are veteran psychotherapists, we tend to think with a beginner's mind.

Part one of our book describes the dialectical cotherapy¹ approach that was developed by the authors (and Sarah Gafni) and its theoretical bases; its unique application with: unsuccessfully terminated treatment cases; phobias using a combination of flooding and desensitization techniques simultaneously; a highly resistant enuretic child via a "phantom co-therapist"; inhibited children, in combination with the Thematic Apperception Test and Gardner's Mutual Storytelling Technique; couples group therapy.

In part two, various creative therapy models are presented: Script-Changing Therapy; Dealing with Monsters; Resource Connection Envelope as an addition to the EMDR standard

¹"The unique dialectical cotherapy approach was advocated years before dialectical therapy became a treatment of choice in many cognitive behavioral schools." (Professor Stanley Schneider, Hebrew University, in a personal communication to the authors).

protocol; an integrative tool of intergenerational therapy which is based on dialogues with family members through Persona cards. Also described in this part, are several cases of the effective interventions of clergymen, working in tandem with a psychologist, in the treatment of patients suffering from pathological guilt and a unique group therapy approach.

Part three presents two unconventional supervision approaches with trainees; the personal reflections of two former patients, in collaboration with one of the authors; the musings of the latter regarding the use of mobile chairs and touch in therapy, and in being an eclectic therapist.

We hope our book will encourage greater open-mindedness, flexibility and creativity on the part of clinical psychology students, trainees, beginning and seasoned psychotherapists, and expand their armamentarium of psychological tools, techniques and interventions in their clinical work.

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This book is dedicated to our respective spouses and children:

Betty and Nachum, Gershon, Miriam.

Felix and Maya, Adam.

And to the blessed memory of Louis and Sheldon Rothstein.

Part 1

Dialectical Cotherapy Approach

Dialectical Cotherapy

Seymour Hoffman Brurit Laub

Cotherapy

Cotherapy is the simultaneous treatment of clients (individuals, families and groups) by two therapists working together. "It is a specialized technique in the art of therapy". (Keith and Whittaker, 1983)

In the last two decades, cotherapy's popularity has increased, especially in the treatment of families and groups, and to a lesser extent, with individual clients.

The advantages and benefits of cotherapy are considerable:

1. It expands the fund of creativity, range of interventions and techniques.
2. It enhances the transference and improves control of counter-transference.
3. Therapists complement each other in knowledge, skills and personality.
4. It enables cotherapists to have different positions when one therapist holds back and observes, while the other actively interacts with the clients.
5. A positive model of interpersonal relationship is provided.
6. The treatment process is enhanced and shortened.
7. Mutual support and supervision is provided.
8. Sharing of responsibility and decision making.
9. Burnout is reduced.
10. Training of a less experienced cotherapist by a more experienced one.
11. Active interaction between therapists facilitates externalization of covert conflicts and ambivalence.

Cotherapy is not necessarily tied to a particular theory or psychotherapeutic approach. Thus, it is a tool of considerable versatility that can be used in many ways and settings.

Dialectical Cotherapy

The male-female polarity plays an important role in the process of socialization. Children, unwittingly, are influenced by the contrasting attitudes and behaviors of their parents toward them and the significant people in their environment. Father and mother represent two models for relationship; the mother expresses unconditional love and acceptance and provides the child with emotional encouragement and support while the father expresses expectation, responsibility, limitations and discipline. The former fulfills the nurturing role, the latter, the instrumental role. The former provides for the child's emotional needs so that he/she can cope with life's challenges and demands, the latter, the tools. Both contrasting and complementary influences are vital in order to insure that the child grows up to be a healthy and contented person.

The male-female polarity was utilized in the development of a psychotherapy approach named "dialectical cotherapy". This is a specific approach which capitalizes on the different and contrasting traits and roles of the co-therapists. In this approach, the therapists actively interact with each other and with their clients. They share their views, feelings and perceptions in front of the clients, model selective behavior, role-play, intentionally take opposing sides on issues, and sometimes participate in paradoxical interventions.

One therapist is supportive, nurturing and empathic, while the other is confronting and challenging. The former relates to the affective needs, wishes and fantasies of the client, emphasizes her strengths, positive attributes and desire and capability to change and grow, while the latter relates more to the negative aspects, obstacles and fears and is skeptical about her motivation and capacity for meaningful change. He is more instrumental, goal and reality oriented and challenges the client to prove him wrong. This approach promotes, in a quick and effective manner, the uncovering of underlying conflicts and ambivalence and makes them more readily available for therapeutic work and resolution. (Hoffman, Gafni and Laub, 1994) As Whitaker (1997) has put it: "One therapist performs the surgery and the other the anesthesia".

Using the dialectical approach for more than a decade we have been impressed with its effectiveness, especially, in treating highly resistant and poorly motivated clients, in emergency situations that

require an immediate focused intervention, and in situations of therapeutic impasse. In these situations, frequently a consultant-co-therapist is invited into the therapy for one or a few sessions in order to extricate the therapy from the quicksand in which it is embedded.

A consultant-cotherapist, can be more objective, insightful and free to act and say things that the primary therapist would hesitate to do. Whitaker refers to the mother-father (male–female) metaphors when describing the cotherapeutic relationship: "It seems that the initial therapist is contaminated with all the usual problems of being a mother. He's all forgiving, all accepting and minimally demanding. In contrast, when the consultant comes in for the interview, he turns out to be very much like the father. He is reality oriented, demanding, intellectual, much less tempted to accept the original complaints of the original presentation and much freer to think about what's being presented in a conceptual total gestalt manner" (Whitaker, 1976). A consultant can make outrageous interventions or suggestions, raise highly sensitive and painful issues and be provocative in questioning the patient's motivation and capacity to benefit from therapy and change, without being concerned about future repercussions or the effect on their relationship (Papp, 1983). All this, obviously, can be done only after prior discussion and collusion with the primary therapist.

The choice of the consultant is determined by his qualities, expertise, specific skills and background. For example we invited a rabbi to “unstick” the therapy when issues of extreme guilt feelings impeded the therapeutic process (Laub and Hoffman, 1987).

Recently we described the use of “dialectical letters” addressed to clients after therapy was terminated. These letters can pose a challenge for future resolution when treatment ended unsuccessfully, or provide a better closure. They can also be used to terminate successful therapy in which case they serve as a “validating certificate” (Laub and Hoffman, 2002).

Anecdotal example

Following is a brief anecdotal example to illustrate dialectical cotherapy.

A ten-year old boy was brought to the clinic by his parents because of immature behavior and encopresis which began several

months following the birth of a sibling. After several unfruitful sessions, one of the therapists declared that the child, because of his emotional immaturity, was not capable of controlling his bowels. Therefore he must be treated according to his emotional and not chronological age which means using diapers, limited privileges, restrictions, etc. The child vehemently protested and insisted that he was capable of sphincter control, to which the therapist scoffed. A discussion followed between the cotherapists, whether the child was capable of controlling his bowels or not. The female therapist, expressing a more optimistic opinion, insisted on giving the child a chance to prove himself before implementing the new approach to which the male therapist grudgingly agreed. The child returned the next session with a chart indicating significant decrease in "accidents" and a triumphant expression on his face, much to the "chagrin" of the "pessimistic" therapist. By joining with the child against the "mean" therapist, the "kind" therapist was able to induce behavior change in a relatively short period of time.

Theoretical background

Omer, (1991) views dialectical interventions as "treatment strategies that embody two antithetical moves in such a way that as the pendulum swings from one to another, change forces are mobilized and resistances neutralized. These interventions consist of two coordinated contrary movements that may be thought of as a thesis and an antithesis. Although sometimes the intervention aims at giving maximum power to one of the polar movements, at other times, it aims at emerging synthesis."

Nick Cummings, in a personal communication, commented regarding the dialectical cotherapy approach: "I find that the concept of cotherapy that the authors present is a very interesting approach to create therapeutic momentum. Besides being dialectic, it also delivers a paradoxical message."

Laub's model deals with the application of the universal polarity to the therapeutic situation (Laub, 2001). Polarity is a central concept in eastern and western cultures (Watts, 1963). The concept of polarity is one of the main elements in the Kabbalah and is described as the male element (right side) and the female element (left side) (Hoffman, 1992). Polarity also plays a

dominant role in various therapeutic methods like Jungian (Jung, 1963) and Gestalt therapy (Perls, 1959).

In the above model, the main focus is on the dialectical relationship between the problem and the healing force (resources) of which dialectical cotherapy is one approach among many, ancient and modern, that utilize the universal polarity. Facilitation of the healing process can be achieved by different techniques, like externalization, which make the poles of the problem and the resources most accessible for processing.

In dialectical cotherapy, the problem pole is represented by the "bad" therapist who takes a pessimistic position regarding the possibility of change and emphasizes the difficulties and the fears of the client. The pole of the healing force is represented by the "good" therapist who takes an optimistic position with regard to change, expressing his confidence in the client's ability to use his resources and overcome his problems.

In this direct and lively discussion between the therapists, the therapists relate to the client's thoughts, feelings and behavior. This dramatic and vivid "argument" which is both enticing and unpleasant, enhances the accessibility of the poles. It allows for the externalization of the intra- and interpersonal conflicts via the polar interaction between the therapists. The clients are faced over and over with their inner polarities while the dialectic tension accelerates the process of reaching a synthesis or a new balance.

Another aspect of polarity in the above approach is the dialectical pair of connection and separation. This pair refers to two processes which take place in the therapy room. One is intense intra and interpersonal involvement. This involvement (connection) is enhanced by the dramatic and provoking argument of the cotherapists. The second process is one of distancing (separation). It allows clients to assume a position from which they can observe and compare their perceptions, views and feelings with those of the therapists as if from the outside. This dichotomous attitude is a well known principle practiced in meditations (Thich Nhat Hanh, 1991). In mind-body therapies, it is mentioned as a most important vehicle and given different names like: "Dual Attention" in EMDR (Shapiro, 1995), "elliptic consciousness" (Bontenbal and Noordegraaf, 1993) and "the third position" in NLP (Bandler and Grinder, 1979).

The observing position of the clients opens different options such as introducing new information into their peripheral hearing without frontally threatening them. As a technique, it circumvents a direct affront on defended and impermeable boundaries, hence avoiding client early mechanisms of resistance (Hoffman and Gafni, 1984).

In couple cotherapy, one therapist can express an inner voice of one partner, thus helping the other to see the situation from the point of view of his spouse and circumventing the usual power struggle. It may also help the client to get in touch with a covert issue which he had projected on his spouse.

Objections and reservations

We encountered common objections and reservations regarding cotherapy in general and dialectical cotherapy in particular:

1. The use of two therapists is not economical, especially in today's climate of health-care cost consciousness and accountability.

It is our experience that focused and direct cotherapy significantly shortens treatment, and therefore, in the long run, is economical. The average number of sessions is between eight to twelve. An additional benefit is the "live supervision" the trainee receives in working with an experienced therapist (Bernard, Banineau, and Schwartz, 1980; Roller and Nelson, 1991; Yerushalmi and Kron, 2001).

2. The reactions of the clients to the cotherapists' interactions are in question. Are they really taken in by the "dialectical charade"?

In our experience we have encountered various client reactions to the dialectical interaction of the cotherapists. Some clients react in a very serious and involved manner. Frequently they express anger towards the bad therapist and doubt his professional competence. A charming example of this is an emotional response by a selectively mutistic child to the "bad" therapist's provocative intervention: "The psychologist is an idiot". The father, who was an electrician by profession, explained to the therapists (the authors), at the conclusion of the successful treatment, that while there was a positive connection between his daughter and Brurit, there was a short circuit between her and

Seymour. The reason that she began talking to the kindergarten teacher and other adults was to prove that the latter was wrong. He concluded that there was a need for a plus and a minus in the therapeutic situation in order to induce an electrical current (change of a static situation). Two pluses ("good" therapists) or two minuses ("bad" therapists) would not have produced positive results (Hoffman, Gafni and Laub, 1994).

In a family therapy meeting, a client reacted to the dialectical element: "Since Brurit is a woman, she can be soft and since Seymour is a man, he has to be hard" (Hoffman, Gafni and Laub, 1984).

Other clients relate to the cotherapists' dramatic dialogue in a more playful way. Although they regard it as some kind of acting, they appreciate its effectiveness, because it genuinely resonates with their own complex inner world. For example at the end of one marital therapy session, the husband spontaneously stated: "You are excellent actors, you are also highly professional people. Through your interventions I am better able to recognize and understand my anxiety and conflicts" (Hoffman, Gafni and Laub, 1994).

3. The dialectical cotherapy approach is very manipulative.

The use of manipulation in psychotherapy is a moot issue that has produced wide debate and heated reactions among psychotherapists of all persuasions (Brown and Slee, 1986; Haley, 1976; Frances, Clarkin and Perry, 1984; Weeks and L'Abate, 1982).

Manipulation is involved in all forms of therapy, ranging from analytically oriented to behavioral and strategic, though it may not be that obvious in all forms. Manipulation is nothing more than influence and in therapy "one cannot not influence" just as one "cannot not communicate" (Watzlawick, Weakland and Fisch, 1974). The question is not whether to influence or not, but how to do it in the most humane and constructive manner in order to effect positive change.

Conclusion

Cotherapy, in general, and dialectical co-therapy in particular, significantly adds to the complexity, richness, flexibility, brevity and effectiveness of the therapeutic process. As Dick, et al. put it, "We do cotherapy because people often get what they come for

more quickly, because we continue to experience significant mutual learning and support, and because we like each other and have fun working with each other" (Dick, Lessler and Whiteside, 1980).

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“Dialectical Letters” – An Integration of Dialectical Cotherapy and “Narrative” Therapy

Brurit Laub Seymour Hoffman

Dialectical cotherapy

Dialectical cotherapy is a specific cotherapy approach which utilizes the different and contrasting traits and roles of the cotherapists as they interact with each other and their clients. From the onset of treatment until positive change has been realized, the cotherapists take consistently opposing views and functions. One therapist is supportive, nurturant and empathic, while the other is confronting and challenging. The former relates to the affective needs, wishes and fantasies of the client, emphasizes her strengths, positive attributes and desire and capability to change and grow, while the latter relates more to the negative aspects, obstacles and fears and is skeptical about her motivation and capacity for meaningful change. He is more instrumental, goal and reality oriented and challenges the client to prove him wrong. This approach promotes, in a quick and effective manner, the uncovering of underlying conflicts and ambivalences and makes them more readily available for therapeutic work and resolution (Hoffman, Gafni & Laub, 1994).

Theoretical background

Omer views dialectical interventions as “treatment strategies that embody two antithetical moves in such a way that as the pendulum swings from one to another, change forces are mobilized and resistances neutralized.” (1991)

Laub’s (2006) model deals with the dialectical relationship between the problem and the healing force (resources) of which dialectic cotherapy is one approach among many, ancient and modern, that utilize the universal polarity. This