Integrative Psychotherapy and Coping With Psychopathological Syndromes: Dilemmas Around the Treatment of a Patient With Resistant Trichotillomania

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The clinical case presented herein addresses the following 2 key issues: (1) the meaning and consequences of bypassing a major symptom or syndrome in a patient’s treatment to facilitate development and growth in other dimensions of her life that were being hindered due to their interrelations with the symptom; and (2) the therapeutic impact of incorporating strategic, cognitive, and behavioral interventions into a relational psychodynamic psychotherapy modeled on Wachtel’s (1997) cyclical psychodynamics theory. The primary distress, symptoms, personal, and family background of the patient are outlined, followed by a description of the psychodynamic formulation and detailed clinical considerations lying behind the adoption of a cyclical integrative therapeutic plan. The treatment plan comprised strategic intervention, interpretative work around the psychodynamic formulation, cognitive challenging, augmenting self-esteem, reinforcing active and independent behaviors, with a focus on the therapeutic effects of therapeutic alliance, and corrective experiences. The discussion, outcomes, and conclusions sections demonstrate the importance of adopting creative, flexible, and integrative attitudes when working with patients suffering from defined complex symptoms among other complaints and distresses.

Keywords: trichotillomania, integration, psychotherapy case formulation, cyclical psychodynamics

This case presentation addresses a situation whereby the patient’s major symptom or syndrome is not her primary complaint. This therapeutic circumstance is compounded when the treatment is helpful in meaningful areas and aspects of the patient’s life but does not mitigate the major symptom. Significant improvement in other areas of the patient’s life may, in fact, be partially achievable via bypassing the symptom. This therapeutic process raises serious clinical and ethical concerns: is it acceptable and/or successful? Is it a creative and effective means of coping with a complex clinical situation or indicative of failure on the therapist’s part?

I suggest that, sometimes, bypassing the symptom may allow processes of change that had previously been arrested (Haley & Richeport-Haley, 2003), especially when concentration on the symptom leads the patient to structure her identity around it as part of her attempt to preserve pathological personal and interpersonal equilibrium. In such cases, focusing on the symptom may unwillingly strengthen the pathological equilibrium, the therapy itself thus contributing to the problem. Bypassing the symptom, on the other hand, may allow change and development in central areas of the patient’s life that the symptom seeks to arrest in of its attempt to maintain pathological equilibrium. This scheme is not relevant, of course, when the patient is specifically looking for the alleviation of her symptoms.

Second, it seeks to exemplify the ways in which strategic, cognitive, and behavioral interventions can be incorporated into psychodynamic processes. This integrative endeavor is conceptualized in terms of Wachtel’s cyclical psychodynamics model (1997), which proposes...
a cyclical understanding of the patient’s distress, symptoms, and functional impasses.

**Dana—Principal Distress and Symptoms, Personal and Family Background**

Dana was 23 when she began therapy. She had just finished the first year of her undergraduate studies in an interdisciplinary program for outstanding students, and was still living with her parents. We have been meeting regularly for 7 years and the therapy is ongoing.

The first sessions were primarily devoted to Dana’s account of her anxieties. Although she had suffered from trichotillomania (TTM) since the age of 15, her studies were now the primary source of tension and obsession in her life. She found making decisions very difficult, relying heavily on her parents—especially her father—to help her figure out how to cope with her academic assignments and everyday living.

My first impression of Dana was that she was lively, energetic, and charming. I immediately felt a strong sense of fondness and affection for her. My experience of her was in sharp contrast to her own perception of herself as anxious and helpless.

Her anxiety had begun to escalate from the age of 12. When she started experiencing panic attacks and obsessive ruminations, her parents sent her to psychotherapists and psychiatric consultations. She was prescribed antianxiety medication—which she is still taking. Beginning when she was 15, her TTM fluctuated in severity over time. A year of cognitive-behavioral therapy started when Dana was 15 partially alleviated the symptoms. This ended, however, because she felt it made her even more nervous than before. Immediately afterward, her TTM intensified again and she commenced a psychodynamic therapy. Although she felt understood and contained in this, her symptoms did not abate and her parents encouraged her to stop after two years. This point in time coincided with her recruitment to military service.

Dana described her father—a senior physician—as an intelligent and opinionated man. He was accustomed to telling all the family members—especially Dana—what they should do, becoming very offended when they disregarded his advice. On occasion, he would lose his temper and throw things when frustrated. Dana’s tendency to consult with her father over virtually every aspect of her life was marked by an obsessive quality.

According to Dana, her mother—a nurse by profession—was depressed and helpless. Belittled by her husband, she adopted Dana as her ally, sharing her thoughts about leaving her husband with her. At the same time as feeling hopeless, however, she was also proud of her looks and fantasized about starting a new relationship.

Dana identifies with her mother. Whereas the father is domineering toward both, his attitude toward them differs markedly in certain respects. Despite respecting Dana’s abilities, he feels that he is the only one who can help her fully fulfill her potential and must therefore be allowed to control her decision making. In contrast, he perceives his wife as weak and helpless—the same way in which she regards herself.

Dana’s mother is a Holocaust survivor. Only 2 years old when her parents entrusted her to a Christian family who raised her on a farm until the end of the war, she never saw her parents again. At the age of 7, she came to Israel with a group of other children, growing up on a kibbutz with an adoptive family. Her recollections of her childhood are of constant estrangement and loneliness, accompanied by the feeling that she was “not Israeli enough.” After she left the kibbutz at 18, she maintained no contact with her adoptive family—or any other members of the kibbutz.

Her father’s parents married because it gave them a way of reaching Israel at the outset of World War II. Shortly after her father’s birth, Dana’s grandfather abandoned the family, leaving her grandmother to raise her father alone, without any support, all her family being killed in the Holocaust. She adored her son, nurtured his talents and self-esteem, and worked hard to fulfill his needs and wishes. He met all her expectations, becoming an outstanding physician. Dana thinks her grandmother was the only person her father truly respected. Unsurprisingly, she was devastated when her son chose an impoverished orphan as his wife. This choice, however, enabled him to preserve his strong bond with his dominant mother.

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Dana’s parents were 22 and 25 when they married. Dana’s brother was born 8 years later,
after numerous fertility treatments. Dana herself was born 14 years later, after her parents—now 44 and 47—had given up all hope of having another child.

Dana’s brother—a successful physician in his own right—is his father’s pride and joy. Father and son enjoy one another’s company. In family gatherings, they discuss extremely important matters while excluding Dana and her mother from the conversation. When Dana consults them, they act high-handedly toward her, reacting angrily to any doubts she expresses regarding their advice.

Dana’s account of her childhood years is ambivalent. Though she portrays herself as a sweet and vibrant child, she also says she was insecure, anxious, and obsessive. She had numerous pets, some of whom slept in her bed—giving rise to her nickname, “Dr. Doolittle.” At the age of 21, after her military service, she began work as a guide in a boarding school in order to make money to travel around the world. There she met her partner, to whom she is now married. Her father encouraged her to enroll in an undergraduate interdisciplinary program for outstanding students. When she did so, it meant the abandoning of all her dreams of traveling. Both her parents disapprove of her partner, her father especially frequently doubting his capabilities.

Dana’s TTM grew worse when she began studying, the stress and long hours spent on her own aggravating her symptoms. This was a familiar pattern. With some embarrassment, she reported the pleasure the pain pulling out her hair gave her. She also gained satisfaction from the feeling that accompanied crushing the tip of the hair between her teeth. She couldn’t explain the solace this gave her. She coped with the severe baldness she caused herself by using hair extensions. Her parents, extremely obsessed over her TTM, tried to persuade her to stop pulling out her hair.

Despite defining her TTM symptoms as “awful,” Dana did not identify her hair-pulling as the primary goal of our therapy. She was far more concerned with finding a way to cope with her studies: what was the best way to study for an exam, how could she give a presentation, what subject should she choose for her assignment? Her most pressing need, she felt, was to work on improving the skills necessary to enable her to graduate. The TTM was a side issue.

**Psychodynamic Case Formulation**

The psychodynamic formulation I constructed after the evaluation phase was based on the special role assigned to Dana in the family. Her birth was a kind of miracle for her parents. Her mother had been traumatized first by her abandonment as a child and then again by the alienation and loneliness she experienced on the kibbutz. Her father adopted the role of being the only source of hope and happiness for his lonely mother. Dana thus unconsciously learned that her very existence—and their need to take care of her—were crucial for her parents. She thus could not allow herself to outgrow her role: if she was to become independent, they would be left alone with their unbearable pain. Dana’s role as the identified patient (Drell et al., 2009) in the family thus united the family unit and prevented future separations.

The mother’s bond with Dana was a counterreaction to her early experiences of abandonment and loss. Dana internalized both her role as her mother’s life-sustainer, while also unconsciously internalizing her mother’s trauma, dissociation, and feelings of loneliness and estrangement. Traumatic pain such as this being unbearable, it cannot be articulated (Stern, 1983). In this sense, Dana’s TTM may symbolize the “unspeakability of the trans-generational trauma” (Faimberg, 2005) passed from one generation to the next as a lacuna in consciousness, inaccessible to mourning (Laub & Auerhahn, 1993). This view is consistent with the current understanding that the etiology of TTM involves biological, psychological, and social variables (Gershuny et al., 2006; McDonald, 2012).

On the other hand, the TTM also symbolizes Dana’s own aggression and sexual drives—expressed in the satisfaction it gives her. The damaging of her looks and the pain involved in the hair-pulling mitigate the guilt associated with her oedipal link with her father (Stein, Christenson, & Hollander, 1999). Their relationship is played out as a sadomasochistic dance characterized by dominance and rebellion.
Clinical Consideration as Rational for the Therapeutic Plan

Taking into account that
- Dana’s major complaint was the stress and anxiety induced by her studies and her dependency upon her father;
- her relapse after a CBT that focused upon dealing with the TTM—a common feature of such treatments (Franklin, Zagrabbe, & Benavides, 2011; Lerner et al., 1998);
- the emerging hypothesis in the literature that integrative cognitive emotional therapies such as DBT (Dialectical Behavior Therapy) (Linehan, 1993) and ACT (Acceptance and Commitment Therapy) (Robinson & Hayes, 1997) are beneficial in treating focused TTM (where the patient is generally aware of the pulling) whereas automatic TTM (where the patient is generally unaware of the pulling) responds better to behavioral techniques (Franklin et al., 2011);
- the fact that Dana’s TTM was not characterized by trichophagia, thereby averting gastrological complications;
- the psychodynamic formulation of Dana’s world;
- my evaluation that Dana possesses solid and effective ego strengths;
- and the immediate positive bond that I experienced in my early relationship with her

I chose to devise a treatment that combined strategic intervention, interpretative work around the psychodynamic formulation, cognitive challenging, augmenting her self-esteem, reinforcing active and independent behaviors, focusing on the therapeutic effects of the therapeutic alliance, and corrective experiences.

Strategic Intervention

Having consulted Dana’s psychiatrist, I suggested to her that the therapy should not focus on her TTM. I expressed my concern that, given her low motivation to deal with the TTM and her tendency to perceive herself as dependent, focusing on the symptom might shift responsibility for it from her to the therapy. I proposed that we should concentrate on helping her to feel better about herself and becoming more confident as our primary emotional cognitive focus, leaving the decision regarding how to handle the TTM in her hands.

In other words, on the basis of understanding her role as the “identified patient,” the sustainer in her mother’s mental life, and the holder of the “unspeakable trauma”, as well as the failure of a previous symptom-focused therapy, I decided to conduct a strategic intervention (Haley & Richeport-Haley, 2003) and endeavor to bypass the symptom by focusing on Dana’s self-esteem and self-efficacy while striving to create dialectical tension between accepting and challenging the symptom.

Despite her surprise over the proposal, Dana accepted my recommendation. I felt that the challenge of coping with a new situation to which she was unaccustomed was attractive to her. It also appeared to neutralize her habitual resistance to accepting help for which she had just asked. Inspired by findings that ACT and DBT are efficacious in treating focused TTM (Franklin et al., 2011), my work with Dana was oriented toward empowering her while helping her to learn to live with the symptom.

Shortly into the therapy, Dana complained that her hair extensions were falling out and that her hairdresser had recommended that she buy a new and very expensive one. I encouraged her to focus on feeling pretty. The decision having serious financial implications, she was uncertain whether she should ask her parents’ advice about the best course of action. I voiced my opinion that, while she was perfectly free to do this, she appeared to have already made up her mind. When Dana decided that she would nonetheless consult them, her father stated that, in his opinion, continuing to invest in hair extensions was tantamount to letting the TTM win. He criticized the therapy and asked to meet me. With Dana’s consent, I responded that it was important that therapy remain her private space and that even if Dana and her parents disagree, they are able to handle the conflict without any intervention on my part. When Dana finally determined to go ahead and purchase the new hair extension, she was surprised to find that her parents accepted her decision, even telling her how good it made her look.

Processing the Psychodynamic Formulation

As the therapy progressed, I drew Dana’s attention to the way in which her frequent con-
sultation with her parents enabled them to preserve their role as needed caregivers and thereby express their pain, loss, and anxiety indirectly. When Dana’s mother chose to make her privy to her difficult relationship with her husband, I suggested, she was using her as a witness to her present and past hardships. She thereby communicated to Dana her wish that she never abandon her. This interpretation prompted Dana to examine her mother’s traumatic history.

We shared a deep sense of empathy with her parents’ traumas and examined how they had affected their lives. I encouraged Dana to bring photos from different periods of her parents’ lives. Both of us were interested in learning more not only about Dana’s parents and herself but also about our shared collective history. The relational emphasis on the role played by trauma—in its social and historical contexts—in understanding Dana’s inner world led me to propose that her espousal of such values as family cohesion and personal sacrifice was a direct result of the trans-generational trauma. As we talked repeatedly about how she was “destined” to become her parents’ caretaker through nurturing their role as her essential caregivers, I actively prompted her to differentiate between her devotion to them and her role as the “identified patient”—the latter status being responsible for arresting her personal development.

I frequently stressed that concentrating on her symptoms masked the positive aspects of her life. For example, focusing on the anxiety aroused by an assignment prevented her from knowing that she was capable of producing high-quality work—or worrying about her decreased sexual activity distracted her from acknowledging the strong bond she had developed with her boyfriend. In this way she defended herself against the anxiety and guilt attendant upon gaining developmental independence from her parents.

Most of the time, the TTM was fairly mild. There were periods during which Dana stopped pulling her hair at all, and others when the symptoms increased. As the therapy progressed, I grew more and more convinced that the TTM formed an intrapsychic and interpersonal mental zone that, being inaccessible to consciousness, was resistant to change. As time passed, the strategic intervention and the dynamic formulation converged. At times, we even shared respect for the symptom.

**Cognitive Challenging**

In addition to ongoing interpretive work and active efforts to increase Dana’s self-esteem, I actively challenged some of the emotional and cognitive tenets I identified as underlying her distress. These included her belief that she had to disguise the fact that she was helpless and that she needed help in finding the only right way to do things.

**Augmenting Self-Esteem**

To augment her self-esteem, I focused on affirming her ability to function well in all areas of her life despite the tendency to conceal her strengths by exaggerating her dependency.

**Reinforcing Active and Independent Behaviors**

I worked actively to strengthen her active and independent behaviors by reinforcing her decisions regarding what she wanted to study and by what method, bolstering her faith in her decision-making capacities and ability to manage her life vibrantly and creatively, admiring her therapeutic abilities—especially her capacity to communicate empathically with withdrawn children and adults, and empathizing with and endorsing her devotion to her traumatized parents.

**The Therapeutic Effects of the Therapeutic Alliance and Corrective Experiences**

With respect to the therapeutic effects of the therapeutic alliance and corrective experiences, much of my inspiration derived from relational-theory concepts relating to the mutual roles of patient and therapist subjectivity in the development of transference relations (Aron, 1996) and conceptualizations of analytic change as creating new out of the old (Mitchell, 1993, 1997). I believe that the interaction between the enactment of past relationships in the transference and the emergence of new personal and interpersonal experiences within the therapeutic bond facilitated the therapeutic change that occurred in Dana’s life.
I met her dependence on authority figures with similar and complementary tendencies in myself. Like Dana, I tend to develop close relations with idealized men whose authority I simultaneously respect and rebel against. I could thus identify with her strong bond with her father. Conversely, Dana met my need to serve as an authority figure—exemplified in my attempts to guide her. In reenacting this asymmetric relationship, we were drawn into conflicts characteristic of her relationship with her father—me being opinionated and insistent and Dana willfully noncompliant. Working through these enactments and examining Dana’s relational patterns became a central theme in the therapy.

The new patterns of interaction that Dana and I developed facilitated the therapeutic change. In contrast to her internalized authority figure, I was an authoritative female. Our relationship enabled Dana to experience a new pattern of interaction with a caretaker—one based on mutual reflectivity and allowing more than one opinion. The opportunity the therapy afforded Dana of expressing her wishes and needs to a similar-but-different authority figure enabled her both to work through her difficulties with her parents and to develop a new, empowering relationship.

Alternatively, we might say that the therapeutic interaction provided Dana with a corrective experience—in Alexander and French’s (1946) terms—rather than a working through of the transference and enactments and the creation of new from old.

In either case, our work enabled Dana to shift more freely between different self-states while also developing the ability to experience others in various ways (Bromberg, 1996; Mitchell, 1993)—both of which capacities had been impaired by the massive trans-generational trauma (Bromberg, 1996). I endeavored to point out the diversity of her self-experiences: anxious, powerful, confused, determined, knowing, not-knowing. I also encouraged her to recognize that her parents possessed similar multiple self-states. While her father is domineering and aggressive he is also present and devoted. At the same time as being depressed and dependent, her mother also seeks intimacy and demonstrates the strength of character that enabled her to survive the impossible time and again. We also examined the complexity of her parents’ relationship, their endless arguments being set off by their shared passions and vitality—running around the backyard after rabbits and singing lullabies to Dana’s pets, for example.

Discussion and Outcomes

My work with Dana was inspired by Wachtel’s (1977, 1987, 1997) cyclical psychodynamics theory. This ground-breaking model within integrative psychotherapy addresses the way in which interactions between psychodynamic infrastructure, present experiences in the world, and relational configurations affect mental life. In a mutual interaction, present experiences and relational configurations impact the psychodynamic infrastructure, the latter concurrently shaping the person’s behavior, experiences in the real world, and interpersonal relationships.

Cyclical psychodynamics suggests that change in any dimension of the circular model may occur via interpretation, strategic behavioral interventions, novel interpersonal experiences—or a range of interventions operated simultaneously. In line with this theory, on the strategic level, my decision not to focus on the symptom—which I believe preserved her role as the identified patient in the family—but rather to reinforce her coping and creative abilities facilitated changes in her psychodynamic infrastructure as well as in her experience in the world and her behavior. At the same time, the intensive interpretative and cognitive work reshaped her psychodynamic structure and led to experiential, relational and behavioral changes. The reinforcement of active and independent behaviors and the augmentation of her self-esteem had therapeutic impact not only on her behavior and experience in the world, but also on her psychodynamic infrastructure. Simultaneously, the modification of Dana’s relational world engendered by the therapeutic alliance enabled intrapsychic change allowing her to come into contact with a range of self-states—such as being strong, capable and vital—she had previously disowned.

A year into therapy, Dana’s anxieties had significantly decreased and we were focusing our attention on the themes described above. At this point, I suggested that we should reduce the sessions to once every two weeks. This recommendation was based both on the development of her effective coping strategies and a wish to
moderate the continued enactment of Dana’s dependent and helpless tendencies.

The themes outlined above accompanied us throughout the therapy, the issues and challenges varying. Two years into therapy, Dana was faced with career choices after gaining her BA. Although her father encouraged her to pursue an academic career, Dana decided to undertake a graduate degree in clinical psychology. In our discussions, it became clear that while this preference reflected her identification with me, it was primarily a tribute to her enhanced awareness of her caregiving skills. In the face of her doubts that she would be accepted into the program, I prompted her to apply, voicing my belief in her abilities.

Embarking on the MA program, Dana exhibited her customary response pattern, becoming anxious, obsessive, and needy. We examined her fears, discussed her studies, and tried to reinforce her belief in her abilities. I again suggested that focusing on her difficulties allowed her to avoid acknowledging her capacities—an act that threatened her deep dependence on her parents. Once again, we noted the similarities and differences between her relationship with her father and with me around this transition. In my opinion, the combined support and challenge with which our relationship provided her enabled Dana to adjust quickly to her studies. Not only was she able to humorously examine her dependency and anxiety but she even admitted to enjoying the studies. She also demonstrated a developed capacity to acknowledge her interpersonal and therapeutic skills.

Dana described her relationship with her boyfriend as both intimate and childish. He frequently helped her calm down, his presence usually making her feel confident and secure. She shared with me her fantasies about other men. While she wondered whether her partner was good enough for her, she was willing to examine my suggestion that her judgment was affected by her father’s opinion of him. I believe this work helped Dana to differentiate her feelings toward her partner from her father’s attitude toward him—without denying their own problems as a couple.

**Conclusion**

To conclude, I propose that the integration of dynamic, behavioral–cognitive, and relational components organized around a cyclical understanding of the interrelations between the psychodynamic infrastructure, the relational world, and behavioral experiences (Wachtel, 1997) was responsible for enabling Dana to experience a significant change in her self-experience, awareness, interpersonal configurations, and experiences in the actual world. These gains decreased her anxiety and dependency and facilitated her pursuit of a career and romantic relationship.

Similarly, the strategic decision to base the therapeutic change on empowerment, personal growth, responsibility, and acceptance of Dana’s choices rather than seeking to alleviate the TTM; processing the trans-generational trauma and the family dynamics; and creating corrective experiences all demonstrate the importance of adopting creative, flexible, and integrative attitudes when working with patients suffering from defined complex symptoms among other complaints and distresses. This holds true even in cases where the general recommendation is to employ specific manualized or non-manualized models to alleviate the symptom. It is important to emphasize that the proposals suggested above are in no way intended to undermine the importance of evidenced-based psychotherapeutic models. On the contrary, I believe that the therapist is obligated to fully acquaint herself with the most up-to-date empirically based psychotherapeutic models available and consider their use wherever possible. Obviously, a comprehensive clinical evaluation is necessary before designing any treatment plan. In the present case, the strategic intervention was offered after the symptom had been evaluated as relatively mild and related potential health complications excluded. The patient’s motivation to reduce the symptom was further assessed as being low. It also took into consideration the fact that a previous symptom-focused therapy had led to only partial improvement, followed by an immediate relapse. I would like to assert that a dialectical attitude toward the tension between the acceptance of syndromes and deliberate work on change and alleviation is beneficial and at times even crucial for the development and success of the therapy. A sensitive and creative approach is necessary in order to maintain this tension.
References


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