THE INTEGRATION OF BEHAVIORAL PRINCIPLES AND A PSYCHODYNAMIC VIEWPOINT IN THE TREATMENT OF ADOLESCENTS ON AN INTERMEDIATE INPATIENT UNIT

Marc Adelsberg, Ph.D.

This paper describes an approach to setting up an inpatient intermediate-term unit integrating behavioral methods with a psychodynamic viewpoint to facilitate the treatment of severely disturbed adolescents. The need to provide a safe and structured environment for these youngsters is critical to the establishment of what Erikson has described as basic trust. The milieu needs to feel safe and predictable to provide a synergistic relationship with other modalities of treatment. This can usually be accomplished by utilizing behavioral principles within the milieu. Case examples are provided in which interventions on the unit can provide increased feelings of security which then translate into the patient being able to understand, express and work through feelings and decrease the probability of acting these feelings out. An important consideration is also given to intra and inter-staff dynamics and countertransference reactions which impede the exploration of feelings and encourage patients to act out the staff's forbidden unconscious impulses.

A major task which I am interested in relating is the integration of behavioral principles along with an understanding of the dynamic and developmental significance of behaviors in order to
treat adolescent inpatients on a short term unit. One of the most important aspects of constructing such a treatment milieu is the necessity of containing the acting out of these patients who show various types of pathology. By “acting out,” I am referring to a more organized transferential form of acting out as well as the more “unorganized type” or “primary acting out”. (1) The latter is more primitive and has been described as impulsiveness “which is marked by the primitive action of tension discharge”. (2)

The present chapter emerges from six years of work on an inpatient adolescent unit with inner-city youngsters 11–15 years of age. Their diagnoses ranged from Major Depression, Schizophrenia, various Personality Disorders to Post-Traumatic Stress Disorders. Many of these children have learning disabilities as well. All of these youngsters were admitted to the short-term adolescent unit because they were considered dangerous to themselves or others. Furthermore, these symptoms did not remit after one through six weeks of treatment on an acute unit. Most of the children requiring this level of care have been physically and/or sexually abused at least once in their past. Their families range in socioeconomic status from below the poverty level to middle class with the majority falling on the lower end of the spectrum.

In terms of constructing a therapeutic milieu with this population limit setting is a critical variable. Generally, it appears that when “inappropriate” behaviors are allowed to occur without containment, the behaviors escalate into a more dangerous form of behavior. The acting out has the quality of testing staff to see if the behavior can be contained. When this does not occur, the patient’s ability to trust the staff is significantly diminished. This distrust is often based upon the staff’s failure to empathically intervene and understand the youngsters’ need to be contained. It is the thesis here that if behavior is not contained within a “good enough holding environment,” (3) that the developmental process in which actions are labeled and put into words cannot be accomplished. It is precisely the trust that is gained from empathically responding with various limits which allow the processes of “labeling”, “expressing” and “working through” feelings to occur.

One such example occurred with a 13 year old youngster who was diagnosed as having Organic Personality Syndrome and Post-Traumatic Stress Disorder. Her mother had been uninvolved for about one year prior to hospitalization. One of the precipitants of