THE DIPLOMAT

Alvin R. Mahrer
George Stricker
Douglas H. Powell
Laura N. Rice

The Diplomat

Alvin R. Mahrer
George Stricker
Douglas H. Powell
Laura N. Rice

e-Book 2016 International Psychotherapy Institute

From *Therapy Wars: Contention and Convergence in Differing Clinical Approaches*
edited by Nolan Saltzman and John C. Norcross

Table of Contents

The Diplomat

Alvin R. Mahrer

George Strieker

Douglas H. Powell

Laura N. Rice

Case Presentation

The anxious young man calls to inquire about joining a therapy group. At the consultation, Michael wears a black cord sports jacket, white shirt and a narrow black knit tie, and black jeans. His wild hair, sparse beard, and feverish eyes give him the look of a nineteenth-century anarchist. All he lacks is a round black bomb with a smoking fuse.

"I'm a little hyper," Michael says. "Sorry I'm late. Everything went wrong"—he gasps for breath—"when I was trying to leave for here. I haven't slept for two nights."

He touches his beard nervously as he speaks, and I see there is something wrong with his hands. They are puffy and stiff and bluish. I examine one of his hands. It is cool and leathery to the touch, a corpse's hand!

“I can’t hold a pencil most of the time,” Michael says. “That’s really a pain, because I have to write in the field, where there’s no typewriter for twenty blocks.”

“You have poor circulation in your hands, Mike,” I say. “How long has it been like this? What do the doctors say?” "I’ve had it since puberty,” he says. “It wasn’t so bad at

first, but it gets worse as time goes on. I’ve had a million tests. I’ve got a letter from the head of vascular disease to the head of endocrinology. It says, ‘We have to watch this young man closely,’ and it gives positive indications for four serious diseases it might be, and also why none of these can be diagnosed at this point. It might turn out to be any of them.” “I’d like to see the letter,” I say. “I wonder, does the doctor who wrote the letter say anything about fear? Has anyone related these symptoms to your emotions?”

“Yes, one of the internists at the hospital sent me to a shrink, who put me on Valium, and aminophylline and ephedrine for my breathing. I don’t feel that afraid, but I’d like to believe it’s only fear instead of some terrible disease.” “Are you aware when it’s better or worse?” I ask.

“It’s a little better when I’m having a good time. Sometimes my fingers get almost pink. When I’m anxious, like when I think about going into group

therapy, it gets worse, and my hands hurt."

"Do they hurt now?" I ask.

"Yes," he says.

"How about when you go out on a date with a new girl?" "About like now."

"What are you afraid of in group therapy?" I ask. "Let your imagination go. What do you see happening?"

"I'm afraid of how I might come off in the group," he says. "I can see myself feeling above it and making clever remarks, and then everybody'd jump on me and crush my body and tear me limb from limb."

"You really see the group tearing you apart," I say. "Tell me, where am I meanwhile?"

"You're leading them. You start off," he says. "You hit me in the face and then the others rush by you and jump on me."

Michael knows that this scenario is unlikely. He expects my next question, about relationships in his family. "I'm the only one the others get along with," he says. "I have an older brother and sister and a younger

brother and sister. My father and mother are separated now. Everyone in the family hates everybody else most of the time, but the alliances shift now and then. It's like power diplomacy among nations with armies along their borders."

"And you're the diplomat, the peacemaker?" I ask.

"Peace is out of the question," he says. "I don't even know what I'm supposed to be negotiating."

"Just that they'll keep liking you and not jump your borders?" I ask. "How did your parents treat you when you were little? What's the earliest you can remember?"

"Something I thought of before," Michael says, "when I said about you hitting me in the face. My father used to hit my older sister Cathy in the face. It terrified me." His eyes, the pale, taut appearance of his face, his posture, and his husky voice all suggest that he lives constantly in fear.

"Did he ever hit you?" I ask.

"No," Michael says, "hardly ever. I was considered too sickly to hit. Also, I was supposed to be the intelligent one, and he didn't want to bash in my brains. He used to chase Jack all over the house, hitting him wherever he

could. That didn't bother me, because I figured Jack could take it. But when he hit Cathy, I went to pieces."

"You loved Cathy," I say. "What did you do when your father hit her?"

"I wanted to cry, 'Stop!' but I couldn't. I could hardly breathe. I couldn't go over to her afterward. I stayed away from her for days."

"You were afraid it was contagious," I say.

"That's it!" he cries. He is winded, takes long breaths to catch up.

"How did your father feel toward you, Michael?" I ask. Michael closes his eyes and sinks into himself. "I don't know," he says at last. "He worked long hours. He was an intelligent man trapped by the depression into running a candy store. He always thought he should have been something more. He was remote from me, guarded, as though I might do something to disgrace him."

"Such as?"

"Something effeminate, maybe. I don't know. I can see him grinning at me from behind the counter." Michael shivers.

"Not a smile of being glad to see you," I say. "What did the grin say?"

“It was mean, almost scornful,” Michael says. “How could you be scornful of a little kid, your own son?”

“How could you hit your own daughter in the face?” I ask. “Would you do that, Mike?”

“God, no,” he says. "But you’re getting a one-sided view of my father. He can be gentle sometimes. Both my parents are big on charity. They adopted an asthmatic kid off the streets and raised him. Bobby slept in my room with me and my younger brother, and I remember waking up a lot with both my parents standing over him, trying to make him comfortable and keep him breathing.”

“How did you feel about that?” I ask.

“It hurt that my father was affectionate with him,” Michael says. “Really, he was a kind man, but I couldn’t get any. I always had trouble breathing myself, especially breathing out, like I have a weight on my chest. My mother took me to the doctor. He said there was nothing there. My father believed I would stop complaining if I saw someone with a real problem.”

“So, he turned your bedroom into a clinic,” I say. “How do you feel toward your father now?”

“It’s funny,” Michael says. “I still want him to look at me the way he looked at Bobby, the asthmatic kid. Another thing, he always sent me money, supported me when I was at CCNY and floating around until I became a social worker.”

“How do you like social work?” I ask.

“Great, I love it,” he says. “I have too many cases, like everybody. Can you imagine all that can go wrong between visits to seventy-four desperate ghetto families? I can’t physically get around to see some of them for weeks. I don’t know who’s going to get into trouble or die before I get back to them.”

“How about your mother, Mike?” I ask. “What kind of a person is she?”

“What kind of person? She’s who she is, very powerful behind the scenes, always gets her way, manipulative. She used to keep us in line by saying, ‘You’ll upset your father.’ He’s supposed to have a heart condition, which I think will finally kill him off in another thirty or forty years. My mother decided I should be a priest, so I spent three years in the seminary.” “Do you still consider yourself a Catholic?” I ask.

“Hell, no,” he says. "I hate that stuff now. I can’t tell you how I hate it. Every time I see a nun or priest on the street! Someday I’m going to kill one, and they’ll put me away for good.”

Michael is not going to kill anyone, but plainly he is afflicted by images of killing. He leans forward, eyes blazing, mouth taut with anger. His arms bow tensely, as though he were holding himself back from attacking someone. "You have no idea," he says. "I see myself taking an ice pick and smashing it through some goddamned priest's forehead." "Then what happens?" I ask. "How do you feel after you imagine that?"

"I never think. . . . I just thought of something," he says. "Showing my mother the priest's head with the ice pick in it and his skull's cracked like a pot and the brains running out. And I'm screaming! 'Ma! Look! I killed the phony Jesus!' " "And she responds by . . . ?"

"By crossing herself and giving me a look."

"What does the look say, Mike?"

"I don't know. Wait, it says two things. 'I don't want you,' and 'If nobody else wants you, if you're really *loathsome,* I have to take you.' "

"What did your mother want from you when you were a little boy?" I ask.

"She had some idea of a gentleman in her head. She wanted her children to be ladies and gentlemen. Whenever I heard those words I felt like puking.

Throwing up."

"You just did it for her," I say.

"Did what?" he asks.

"Cleaned up your act for mother," I say. "Substituted a nicer phrase. Doesn't it make you want to regurgitate?"

"I actually remember her saying, 'Puke is common,' " Michael says. "I thought 'common' sounded terrific. It's what I always wanted to be, but I could never make it."

"Was she affectionate?" I ask. "Did she hug you?"

"All the time," he says.

"What was the quality of your mother's hugs?"

"She was smothering. It seemed to me there was something sexual about the odor of her body when she hugged me—she's a big woman—but it was hard to think that because she's so religious."

"You felt she was sexual toward you?" I ask.

“Not exactly,” he says. “I could be reading that in. She used to call me ‘darling’ a lot, and that made me feel sick. It was like I was her way of getting back at Dad.”

“For what?” I ask.

“I don’t know,” Michael says. “Just that I was the means.” “How old were you when you first felt this?” I ask.

“As early as I can remember,” Michael says. “I don’t want to sound precocious, but in the second grade, I got a valentine card from her, and I hated it because I already knew valentines were for real lovers.”

“How about now? How’s your love life?” I sense a defeated quality about him.

“I have a girlfriend, Heather,” he says. “But I don’t think she wants to go out with me anymore.”

“What went wrong, Mike?” I ask.

“She’s very shy,” he says, “lives at home. I don’t know if she’s ready for a real relationship.”

“How old is Heather?”

"She's old enough, my age, twenty-eight."

"I don't understand, Mike," I say. "What do you want with a twenty-eight year old who lives at home, isn't ready for a relationship, and doesn't want to go out with you?"

"I love her," Michael says. "These things don't always make sense. I'm very romantic."

"I'm beginning to see that," I say.

"Tell me, how was sex with Heather? Or, let me ask something first. Have you had sex with Heather?"

"We're platonic," Michael says.

"I haven't heard anyone use *platonic* that way in twenty- five years," I say. "I bet your fourteen-year-old clients aren't platonic."

"They're not," he says. "The girls get pregnant and I'm supposed to sort out their lives."

I cut him off before he can escape into his social work.

"And you're not seeing anyone since Heather won't go out with you."

"I see lots of women," Michael mutters.

"Yes," I say, "and how's the sex with them?"

"I'm not having much sex," he says. His eyelids blink rapidly. He is frightened and alternately pleading and hostile.

"You're not having any sex with women, Mike," I say. "That's not a sin, you know. It's just that you're missing something."

"I can't," he moans, looking away. "I get soft. I even tried with men, in the seminary, to find out what I was. I don't think I'm homosexual. I really am attracted to women."

"I agree with you," I say. "You just haven't been allowed to enjoy a sense of yourself as a sexual man. But you can still learn to be proud of your sexuality." He looks at me as though I had advised him to fly to the moon.

"How am I supposed to do that?" he asks.

A *DSM-III* diagnosis suggested by Strieker is as follows:

Axis I: Anxiety Disorder

Axis II: Passive-Aggressive Personality

Axis III: Impaired respiration, circulation, and potency

Formulations and Treatments

Alvin R. Mahrer (Experiential)

I have two main reactions to the account of the initial consultation. First, I am impressed by the useful experiential material elicited by the good therapist and the good patient. Second, I am struck by how differently I might have worked with Michael.

In the beginning of the initial session, when Michael lets all of his attention go to whatever it goes to, and when he allows himself to feel and to experience, what is the nature of the immediate experiencing? That is where we start. He may begin by attending to his hand and issuing a series of complaints about the hand as he experiences being a captivating new patient. Or, if he began by sinking into recollections of recent incidents with women as he blurts out that he is certainly no homosexual, his experiencing might be of distancing himself charmingly from the ladies.

Where we go from there depends on what happens in the ongoing experiencing. Does it deepen and intensify? Does it give way to some other experiencing? What happens as we work with the experiencings that come

forward? Over the entire session, I need to know the nature of the experiencing and the context in which the experiencing is occurring. I find out by working with whatever good experiential material Michael presents.

The useful material comes from Michael's letting his attention go to whatever is front and center and from his allowing experiencing to occur. It does not come from my framing clinical inferences about Michael or from my leading him into providing information on topics that I select as important. Accordingly, I do not examine his hands, inquire into the history of their condition, inspect letters from physicians, or delve into his heterosexual relationships. Because the information I need is experiential, the methods I would use are those that produce a high yield of experiencing.

I will start from the very beginning. However, from the opening statement, I will have to invent what Michael might perhaps say and do, based on how he seemed to be in the interesting actual session. Because of space limitation, I will proceed only a little way.

P1: I'm a little hyper. Sorry I'm late. Everything went wrong [gasping for breath] when I was trying to leave for here. I haven't slept for two nights.

Tl: [Our eyes are open. We are standing up. Therapy has not begun. So, I am the person I am, being whatever I am.] That's something! You started to leave for here two nights ago? [I motion him to the chair.]

P2: No, I just meant I feel a little hyper, and I know I'm a little late.

T2: [I am ready to begin.] OK, are you ready to start? [He nods.] Just lean back. Me, too, I will. No glasses. No smoking. Feet up. There. Now, close your eyes. I'm closing mine, too. There. And keep them closed the whole time. We'll open them when we are all done. OK? Good. Ready.

I now give standard instructions. In the initial session, if there is already something front and center on Michael's mind, if he is already in a state of experiencing, I want the instructions to give him a chance to attend to whatever is here right now. If there is no special focal center at present, no strong experiencing starting in him now, then there are additional instructions to show him how to locate something to attend to and how to allow himself to experience what is there, waiting.

P3: Uh-huh.

T3: There may be something on your mind right now, something you are aware of and thinking about, something front and center on your mind. It may be something you see, right now, or it may be something coming over you right now, that you can sense and feel in your body. There is something here already.

P4: Hmmm.

T4: Talk out loud. Talk out loud with feelings, any kinds of feelings that are here. Now you can let yourself start to have tears, or you can let yourself get mad, or you can have feelings of being scared or feelings of being gloomy and unhappy, or feelings of smirking, being secret, doing wicked things, laughing, feeling great. Let the feelings happen as you talk about whatever is front and center in your mind right now. . . . Now, I am going to stop, and it is your turn, if you are ready and if you are willing.

These instructions may be enough. They are for most patients in the very beginning.

P5: Well, I called 'cause I was thinking about group therapy.

As soon as I had finished giving instructions, I got ready to let Michael's words come through me, as if they were my words, spoken in and from me. Nothing. The words are dead. No feeling. So, I am once again the instruction giver.

T5: We can start here, with, "I called 'cause I was thinking about group therapy." We can begin with these words. Now, let yourself say them with feelings, with strong feelings, with any strong feelings that come as you let yourself say those words, and then you will be letting the strong feelings come into you.

P6: I can see myself feeling above it and making clever remarks! And then everybody'd jump on me [rising feeling] . . . and crush my body and tear me limb from limb! [a rush of strong feeling]

When these words, said in this way, are as if they were coming through me, suddenly I am in a scene in which six or eight people are at me, pulling my arms and legs. Yet, the most compelling feature is the feeling in me. Actually, it is kind of sexy, vibrant, deliciously out of control. My words express this:

T6: Oh, God! I think I like this!

P7: [He laughs.] But wait'll I tell them the other things.

When these words come through me, there is a sense of wicked exhilaration at the bizarre things I can say, things that will shock them into even more whipped-up craziness.

T7: [Excitedly] Yeah! OK! Here it comes!

P8: I sometimes think about nuns and priests! Someday I'm going to kill one, kill the phony Jesus, stick an ice pick in his skull. It'll crack like a pot and the brains run out!

There is an almost giddy excitement with these words, and a freedom to explode with such delightfully bizarre statements. As these words come through me, I am charged with these feelings, and I can sense a freewheeling kicking off of all restrictions.

T8: Right! Squishy brains, like just pouring out of the damned skull! This is fun!

P9: They'll lock me up! [He is laughing, and there is a wicked sort of devilishness here. As the therapist has these words come resonating through, there is an experiencing of companionship here. It is as if we were buddies being openly bizarre, almost inviting them to lock us up.]

T9: [Buoyantly, like a fellow conspirator] Well, they should! You're a first-class loony!

P10: Boy, do I feel sexy!

These are merely the opening exchanges in an experiential session that may take about one and a half or two hours. We have only begun the first of the four steps of each session (Mahrer, 1989c; cf. Mahrer, 1985, 1986, 1989a, 1989b, 1989d, 1990). To give a fair picture of the four steps, here is a brief

summary of what happens in the rest of this session:

The purpose of the first step is to attain a level of strong feeling. We are not there yet. When we reach this level, there is a genuinely strong degree of charge, force, energy, arousal, saturation, and fullness of any kind of feeling whatsoever. We proceed at Michael's own readiness, pace, and pattern, always in the direction of attaining a level of strong feeling.

Once we attain that level of strong feeling, an *inner experiencing* is accessed, sensed, felt, brought closer to the surface by means of the crucible of strong feeling. This inner experiencing is the jewel. We listen for what it is. It may be something that has been here all along, or it may be something new. Let us suppose that in Michael it is an inner experiencing of wicked, tabooed, devilish, risky, exciting sexuality.

The purpose of the second step is to appreciate this inner experiencing. We let it stay here for a while, we welcome and accept its presence, we enjoy it and let it feel good in us, and we lift up and carry forward its form and shape.

The purpose of the third step is to give Michael an opportunity to be the inner experiencing. The therapist shows him how to move out of the ordinary, continuing personality that he is and how to undergo the radical, massive

transformation into fully being this inner experiencing. To accomplish this, Michael and I search for an appropriate scene or moment from earlier in his life. This is the context within which he can be the inner experiencing. We enter into this context. Michael can now enter wholly into being (living, feeling, behaving) as a new person who experiences wicked, tabooed, devilish, risky, exciting sexuality.

The fourth and final step offers Michael the opportunity for being and behaving as this inner experiencing in the imminent future world. Within the context of scenes and situations from tomorrow and next week and beyond, Michael lives out this newfound experiencing and acts and behaves as this significantly new person. Out of all these new ways of being and behaving, a few are selected, rehearsed, and—providing both Michael and therapist are ready and willing—can be carried out by Michael when he leaves the session. The change in his way of being and behaving may be large or small, significant or insignificant; it may last only a few minutes or from now on, but he has had a sample of what he and his life can be like as this new person.

Now I can complete the answers to the central questions.

With regard to diagnosis and characterization, the sole and critical information is the nature of the inner experiencing accessed in this session. The first step accesses the inner experiencing, and the ensuing three steps

enable personality-behavioral change in relation to this inner experiencing. We have no working use for any sort of psychodiagnosis nor for identification of some problem as presented by Michael, as formulated by a therapist, or as conjointly arrived at by the two of them.

With regard to therapeutic relationship, Michael relates to his own immediate personal world. Both Michael and I attend to this personal world, live and exist in it, experience in it, and relate within it and to it. Michael's words are as if they were also coming in and through me, and all of this is helped by our eyes being closed throughout the session. We do not engage in eyes-open, back-and-forth conversation, attending to each other in the establishment and development of any sort of relationship between the therapist in one role and Michael in some complementary role. In place of our attending to each other in a relationship, I join with Michael in his relationships to and with and in his own immediate personal world.

With regard to treatment methods, I rely on the four steps as the very best way to enable personality-behavioral change in relation to whatever inner experiencing is accessed in this session. This approach leaves aside any so-called treatment of choice for supposed problems or conditions that are maintained from session to session. It also means that Michael is quite free, by taking advantage of any other kinds of treatment programs, to complement whatever experiential sessions offer.

With regard to therapy process, the frame of reference is this session by itself, and not an extended series of sessions. Experiential is a single-session psychotherapy in that each session goes through the same four steps, and each session starts with whatever feeling-related attentional center the patient is ready to start with. There is no presumption of an extended series of sessions, no set of stages of therapy over months or years, no counting on a gradually developing and evolving therapist-patient relationship, no treatment plan for what is to be done in future sessions, and no anticipated future themes of which the therapist should be wary. The term *therapy process* makes sense for the four steps in this session; it does not make sense for an extended series of sessions.

George Strieker (Psychoanalytic)

My approach in psychotherapy is one of continuous hypothesis formation, confirmation, and rejection. Much like the process involved in construct validity, a nomological net is constructed, elaborated, and revised. My framework is psychodynamic, but this same process can be used with any orientation. My approach to the task of understanding Michael and arriving at a treatment plan will follow this same procedure. I will go through the material provided, indicate the thoughts that I have, the confirmatory or nonconfirmatory evidence that later develops, and finally describe a

treatment plan based on this initial contact.

Psychotherapy begins with the first contact, before the patient sets foot into the office. The first question I ask myself, and one the patient answers in both direct and indirect ways, is “Why is he here?” On the telephone, Michael asked for group therapy. Unless the therapist is particularly known for group, and I am not, this is an unusual request. In fact, many patients in public facilities make a point of asking for reassurance that they will not be placed in a group, preferring the attention they will get in individual sessions. Thus, the question from Michael would alert me to the possibility that he wishes to avoid such attention and that he has some difficulties in areas such as trust, closeness, and intimacy.

The information provided in the first paragraph gives an immediate indication that Michael has ambivalence about his relations with authorities and probably adopts a compliant but passive-aggressive stance toward them. Two clues lead to this formulation. The first is combining a rebellious personal presentation (“nineteenth-century anarchist”) with a jacket, white shirt, and tie, but offsetting these by also wearing jeans. The second clue is coming late to the meeting but then feeling the need to be apologetic about doing so.

Michael begins by indicating that he has not been sleeping and generally

presents himself as being quite anxious. I would have responded to that aspect of the communication, asking him to speak further about it. Under no circumstances would my initial contact with a patient be the performance of a physical examination, no matter how superficial the contact. The physical symptoms on Axis III certainly deserve medical attention, and I would want to consult with Michael's physician about them. But I see them as manifestations of the problems outlined above, and I would prefer to address those more directly.

Interestingly, the inquiry into the physical leads to the central role of anxiety, with Michael referring to some doctors in exalted terms (heads of departments) but referring to a mental health practitioner as a "shrink," thus continuing his passive-aggressive mode of relating. I would not have asked about his relationships with women so early in the session, not because I would not want to know, but because I prefer that the patient establish priorities.

The question on the fantasies about group therapy allows Michael to describe his extreme anxieties about being with people. The fantasies are extraordinarily vivid and filled with terror, suggesting the level of anxiety he endures and the extent of the rage he harbors. The next question I would have raised is why he specifically asked to be placed in such a frightening situation. His stated distrust of the therapist, who would lead the assault, may suggest

why he would prefer the protection of a group—even though it might turn against him—to an unbuffered exposure to an authority figure.

I, too, would have gone from these fantasies to his early experiences, in which he learned how dangerous and untrustworthy his surroundings were and because of which he developed his coping tactics. It is clear that these tactics involved passive and avoidance mechanisms, which were only temporarily successful, leaving Michael in a constant state of anticipating harm. Michael's identification with his sister Cathy, combined with his passivity and the power and danger represented by his father, would raise some concern about his gender identity. The hypothesis of a gender identity problem is supported by Michael's apparently self-generated impression that his father may have thought him effeminate. I would further note that, on being invited to express dissatisfaction with his father, he responds by excusing his father and describing his good and charitable acts, all of which were to Michael's detriment. His anger at his father is apparent, but so is his fear of expressing that feeling.

Michael's choice of social work as a career gives him the opportunity to use his considerable intelligence and to provide the care and assistance that he saw his father as providing to others but not to him. At the same time, social work is a profession that is stereotypically regarded as feminine, and one he describes as great (with sarcasm?) before elaborating all the

frustrations and impotence he experiences in it. Career for Michael is a way of identifying with the loved aspects of his father without challenging the feared parts.

Michael's rage against his mother is more manifest. She is less fearsome than his father, so there is less reason to veil his feelings. Further, his feminine identification arid self-loathing combine to allow him to direct his fury at her as an external representation of himself. Michael initially chose the priesthood, also a nurturing profession, at the behest of his mother, but he later rejected it. Here, as in his earlier reference to a group experience, his fantasies are vivid and lurid. His murderous anger is directed at a disappointing father figure, the anonymous priest he does in with an ice pick, which he then presents to his mother. She, in turn, rejects this "gift," Michael's way of acting out her anger at his father, so he is left with a sense of being impotent and unable to satisfy her, whatever he does. The same fantasy also expresses his anger at her by murdering her dream. But here, too, the anger is ineffectual in that she will have to "take him" because it is her duty to do so. This second expression of very primitive rage, to a virtual stranger in a first session, would rouse my concern about the adequacy of his defenses. Nothing presented here suggests that Michael acts out violently, but I would be alert for trouble signs.

As a boy, Michael was expected to behave himself like a gentleman and,

as much as he did not wish to do so, he found himself complying. The interviewer is quite accurate in pointing out how Michael continues to "clean up his act" for his mother. Michael then goes on to describe his sense of being smothered, and the oedipal relationship with her is manifest. The combination of a smothering, seductive mother and a distant, rejecting, and punitive father makes the appearance of an anxious, passive-aggressive, sexually inadequate young man quite understandable. Michael's failure with women is predictable, and his concerns about homosexuality should not be dismissed as easily as they were. I suspect that the theme of insecure gender would be recurrent throughout the course of treatment, and reassurance from the therapist may only serve to block further communication about this sensitive area.

Despite Michael's initial request for group psychotherapy, I would prefer to see him in individual therapy, and he might come to share that preference. The very idea that a male authority would think enough of him to give him individual attention would be reassuring, albeit somewhat frightening, and potentially therapeutically valuable for him. The initial focus in treatment would be on the building of a safe and trusting relationship. I would be continuously aware of his anger but would not press for its expression. I would expect his feelings toward me to be, in turn, angry, idealizing, and homosexual, and I would like him to experience each of these

as safe so that he could then go beyond them and begin to form a sense of his own identity. Observing that I can be comfortable with his anger, he might learn that it is less ferocious than he fears, and this realization might reduce his projection of it onto others and might allow him to function with less anxiety. Finally, as his anger becomes less frightening, his comfort with people should increase, and his physical symptoms might decrease. He might then begin to experiment with more direct expressions of his feelings, which would contribute to his sense of himself as an effective agent in his own life.

Douglas H. Powell (Behavioral and Integrative)

Michael seems to be an ideal candidate for integrative therapy. Impairment occurs across physical, familial, interpersonal, and sexual domains. He is beset by high levels of anxiety and anger, and the anxiety probably contributes significantly to his circulatory and respiratory problems, and to his insomnia. That he reminds the therapist of an anarchist suggests Michael's hostility is not far beneath the surface—an impression supported by his fantasies of being torn apart by a group or of killing a clergyman.

Family issues still trouble Michael. Father's violence toward his siblings and attentiveness to the asthmatic Bobby probably have an effect on Michael's physical symptoms, especially his breathing difficulties. Michael's

relationship with his mother seems more opaque. We know that he sees her as manipulative, controlling, and religious and that she was affectionate to him during childhood; whether she was seductive is not clear.

Michael has pronounced sexual inhibitions. Impotence is one manifestation; avoidance of women with whom sexual intimacy might arise is another. Nothing is heard of a best friend, a group of people with whom he spends time regularly, or even activity-oriented acquaintances. This is a lonely, isolated fellow.

In spite of these difficulties, Michael has a number of resources that are positive for his prognosis. He is bright, and he has used his intelligence to charm his parents, to sublimate aggressive impulses, to pursue a college career, and to enter a field he enjoys and at which he seems quite competent. Michael is able to generate insights and articulate them pleasingly to the therapist, and he evinces a plasticity of ego structure. He can access primitive instincts and experience them without being overwhelmed; this characteristic could lead to more rapid progress than might otherwise be possible. Finally, Michael wants help and has resolved to work with someone who can help him. He appears able to form a therapeutic alliance quickly, perhaps because he has had treatment in the past or has learned from his own studies.

What else would I want to know about Michael? I would like to know

more about Michael's mother and their relationship. How close were they when he was a child? Did they sleep together? Did things change when they took in Bobby? What else did she want from him, other than to be a gentleman and a priest?

More about the origin of the breathing problems would be useful. I suspect these symptoms may be an internalization of Bobby's problems, or they may be associated in some other way—although there is also certainly much more to it.

Because Michael's relationships seem so immature, I would like to hear something about his interpersonal development. Did he have a best friend? Was his same-sex attempt at physical intimacy with a chum? Was he part of a group in junior high school? How about his first experiences with women? What have his twenties been like in terms of his contacts with men and women?

Finally, what does he do fun? What gives him pleasure? Does he go to movies or concerts? Does he like to swim or play with a dog? Is he a New York Mets fan?

In terms of how I would proceed, I would prefer to treat Michael first in individual therapy; group therapy could certainly be useful later. The

question of sequencing in the treatment process may be crucial. After a thorough history has been taken and an initial relationship established—and presuming no clear-cut etiology of the physical complaints— symptom-oriented interventions seem a promising way to begin. I would use autogenic training for the cold hands and hypnosis with guided imagery to try to reduce the severity of Michael's breathing problems. These behavioral techniques have a high probability of also reducing his tension. I would give Michael charts wherein he would rate his discomforts on these symptomatic dimensions. In learning to administer these behavioral techniques himself and following his own progress on his charts, Michael would enhance his self-confidence and would feel less helpless and dependent. The result would be a more collaborative, though perhaps less intense, therapeutic alliance.

During the process of behavior therapy, I would watch for spontaneous insights into repressed affects or cognitions associated with these symptoms. A woman we treated for cold hands broke down sobbing during autogenic training when she recognized how much she resented the attention paid to a crippled younger sister not unlike Bobby. Michael might recognize that his breathing problems are partially related to an internalization of Bobby's symptoms. Such spontaneous recognitions can give insight-oriented treatment a solid beginning.

Michael's psychological-mindedness and his ability to bring up primitive

feelings may enable him rapidly to trace the psychodynamic forces influencing his thoughts or behavior; but keeping him focused on issues, resisting being drawn into interesting cul-de-sacs, and separating central from superficial issues will be a challenge.

I would proceed by asking him to talk about what it is like to be Michael, where he is happy and unhappy with himself, and how he would like to change with the help of the therapy.

I would listen for feelings about his family, especially his mother, because their relationship is crucial to understanding Michael as he is today. Paying attention to the quality of Michael's bonding with friends could lead into his anxieties about sexual identity. He seems heterosexually oriented, but he will have to find his own way. The therapist can help Michael clarify his sexual feelings by encouraging him to verbalize them and reflect on them.

Strong transference, especially with aggressive and sexual themes, might be anticipated. I would expect cascades of anger toward the therapist and others and would want Michael to be prepared early on to recognize and examine the historical origins of the anger. I imagine his anger terrifies him because he has had little opportunity to test it in reality. After he finds that his aggressive thoughts are not lethal, I would help him find ways to express the underlying feelings more adaptively. Perhaps assertiveness training would be

in order.

It is not obvious what form his sexual feelings toward the therapist, if any, might take, although I would look for a sadomasochistic element. Helping him understand any such sexual material and generating insights into their antecedents might be an important element of the treatment.

These understandings could pave the way for a so-called growth-group experience from which Michael might learn to be more comfortable with peers. Such an experience could help him in thinking about what he wants from this phase of his life and motivate him to begin. Group work might begin while the one-on-one therapy is proceeding and then continue as the individual treatment tapers off.

Somewhere along the line, I would encourage Michael to involve himself in recreational activities that would bring him pleasure. This kind of activity could provide some balance in his life as well as introduce him to age-appropriate play.

The therapeutic relationship might go through several transformations. At first, the contact might be more matter- of-fact, as I helped Michael gain control of his symptoms through behavior therapy. Then, I imagine the relationship would heat up as intrapsychic conflicts about self-image,

aggression, and sexuality are explored. I would expect positive transference and transference-based improvement. In the first year, Michael might bring in dreams that would bear on repressed material. Flurries of aggression toward the therapist and others may come out when Michael begins to feel safe in treatment. The primitive nature of these behaviors would be upsetting to Michael, partly because he might fear they would drive the therapist away.

Therapy could be stopped and restarted at various points or supplemented by group or other modalities. But the primary relationship over the years is going to be with a single therapist. Later on, when symptomatic treatment has ended and some of the neurotic conflicts relieved, there will be the more lengthy process of helping Michael cope with normal developmental endeavors, such as establishing an intimate bond, and, if he makes a heterosexual choice, having children. Continuing in therapy could greatly help Michael through the apprehension and ambivalence he might feel about these undertakings.

Michael's therapist should consider whether he or she has the time and is able to commit to working with Michael for several years. Michael would be exquisitely sensitive to the therapist's resistance or to other countertransference feelings about making this commitment. Michael seems to me a highly worthwhile young man; but each of us can have only a few clients like him in our professional lifetimes.

Laura N. Rice (Person-Centered)

I would try, even in the first interview, to begin to establish the Rogerian primary relationship conditions of therapist empathy, unconditional positive regard (which I prefer to call *prizing),* and congruence. I would assume that under the right conditions, he would be able to get in touch with his own crucial inner experience and begin to express it, explore it, and reprocess it.

I would probably not ask many direct questions, especially those involving a change of topic, even in the first interview—except for a few necessary factual questions toward the end. In my experience, a good open-ended reflection can lead to more differentiated information than would a direct question, and such reflection will not sidetrack the person. In other words, the purpose of a good open-ended reflection is to have the client feel really "received" but also to feel free to correct the reflection or to carry it further.

I would respond mainly with empathic reflections. These would not involve the kind of parroting or summarizing that is often attributed to client-centered therapists, but would be a real effort to understand. Unlike many client-centered therapists, I tend to differentiate between two different kinds of reflections (Rice, 1983, 1984). One kind I think of as *empathic prizing* at

times when the client seems very vulnerable, and this kind of primary relationship response seems more important than a response intended to stimulate further exploration. At other times, the prizing is in the background, and the open-ended reflections have the quality of differentiation (Rice & Greenberg, in press).

I try to respond to the part of the client's statement that seems most poignant but not yet fully articulated. Without hearing the quality of the voice, it is hard to tell which aspects feel most significant or puzzling to the client, but in the real interview, one can hear them (Rice & Kerr, 1986). For instance, when Michael talks about his horror at his father's hitting his sister Cathy, I would have reflected briefly his terror when his father hit her, but I would have left the focus on Michael's not being able to go to Cathy for days afterwards. I might say, "It was just awful to see him striking Cathy. But then almost the worst part was later—you couldn't even go near her." This was what seemed most vivid and poignant for Michael but was not fully articulated. My hunch is that he would then explore his feeling of isolation from her, leading into some new path—possibly a feeling that he had failed her.

Michael is obviously extremely emotional, expressing anger, fear, and anxiety that are truly felt. But many of his comments and answers to questions have a dramatized, prepackaged quality. He is deliberately

expressing his most extreme feelings and images. But I sense that his real, differentiated feelings are much more complex and involve aspects that he has never felt he could share with anyone. For instance, when he said, “It’s funny, I still want him to look at me the way he looked at Bobby, the asthmatic kid,” it had a “right-now” flavor, with an open-ended, considering quality, that might turn into something very powerful.

Toward the end of the first interview, I would suggest to Michael that we consider future plans. I would express my own doubts that group therapy would be the most profitable for him at this point and would explain these doubts if he seemed to want me to. I would suggest that individual therapy would be more productive, though a group might be considered later. I think it is particularly important in the early stage of therapy, and from time to time afterwards, to have clients feel free to ask questions about what we are doing and about why I am doing or not doing certain things. If he decided to embark on therapy with me, I would get his permission to talk with his physician.

Early in therapy, I would want him to become aware, either implicitly or explicitly, that we were embarking on a journey of exploration and that I would stay right with him, trying to get a real feel of what he was experiencing and exploring. But I would want him to realize that he was the leader of the search, moving into new territory and developing new awareness and understanding. This might not always be easy with Michael. I

would guess that at times, he would want me to be the expert, even though, at the same time, he would resent it. But I think an honest discussion at such times not only can straighten out the working relationship but also can be therapeutic in itself.

I would expect that the quality of the primary relationship would be extremely important for Michael. From his discussion of his family, it seems probable that he has never felt truly cared about and respected by anyone. He might have some difficulty in working with a woman therapist, but I would not make any interpretations of transference reactions or focus on his relationship with his mother unless he chose to explore it. Rather than making interpretative connections, I think it would be more powerful to disconfirm his negative expectations through the consistency and genuineness of my respect for him and for his ability to discover his own insights and to set his own goals.

I do not think that all this would be easy; I think that it would require a great deal of energy on my part. But I also have the impression that he is an interesting, creative person, and that I could genuinely trust and respect him.

Points of Contention and Convergence

Alvin R. Mahrer

There were a few points of convergence with Laura Rice. On all other points, I seem to differ with all three of the other respondents.

In accord with Rice, I use the initial session as a more-or- less standard session of psychotherapy. We proceed through the same four steps as in every other session. Accordingly, it is not an intake or evaluation session. There is no interviewing about presenting problems, reason for seeking therapy, or case history. There is no assessment of prognosis, state of defenses, psychopathology, ability to form a therapeutic alliance, treatment plan, psychodiagnosis, or treatment of choice.

The patient lives in and relates to his immediately ongoing personal world. So do I. We both interact and relate to it; we live and exist and feel and experience in this personal world. This is made easier because our eyes are closed. What the patient says and does are in and to this personal world. When the patient talks, it is as if the words were coming in and through me. Even while I show the patient what to do as we proceed through the four steps, I am in the patient's immediate personal world, seeing what he sees, undergoing what he is undergoing, relating to what he is relating. Accordingly, we do not engage in the face-to-face conversation of most other therapies, in which attention is largely on one another. This, in turn, means there is essentially no basis for, nor does the experiential therapist try to establish, any sort of relationship, therapeutic alliance, transference, or

person-centered relationship.

In experiential therapy, it is the patient—not the therapist—who is the active change agent, the one who undertakes and undergoes the work of therapeutic change. While the patient is the active therapeutic change agent, I am the one who shows him what to do and how to do it, and I go through the four steps along with him. Accordingly, what I do and say is not an intervention because I do not intervene. I do not administer therapy or do so-called treatment. I do not have private thoughts or make clinical inferences about him. I do not have clever ways of overcoming or disenfranchising or circumventing his so-called resistances to my treatment.

The only important data are Michael's immediate feelings and inner experiencing and the immediate personal world in which he is living and being. That is all. Every time Michael says and does something, I listen for and have the feeling or inner experiencing, and I see and exist in his immediate personal world.

Like Rice, I listen for the feeling. But it is almost certainly not the client-centered feeling. Instead, it is the feeling that occurs in me when Michael's words come in and through me, and as Michael is living and being in his own personal world, I am too. Also, I listen for and see Michael's personal world; once we complete the first step, the key is the accessed inner experiencing

and not the feeling.

Experiential is a single-session psychotherapy. Whether Michael has one or one hundred sessions, each session starts with whatever attentional centers associated with feelings are here right now. And we proceed through the four steps that enable as much personality-behavioral change as Michael is ready and willing to undertake in relation to whatever inner experiencing is accessed in the session. Accordingly, no formulation of a treatment plan is supposed to hold in place over an extended series of future sessions. There is no problem that is supposed to be a stable and continuing treatment target over the series of future sessions. We do not anticipate topics to be explored, nor do we have themes that are expected to occur sometime later.

Our target of therapy, our direction of change, and our criterion of successful change all revolve around the inner experiencing that is accessed in this given session. It is in this very session that Michael has the opportunity to taste what he and his life can be and what the world of tomorrow and perhaps from now on can be. He is being and behaving as this new inner experiencing in the personal world that he constructs. Accordingly, therapy is not a process that is supposed to lead later to some outcome following treatment. There is no formulated treatment plan that is to be achieved later as the direction of successful change. There is no goal of trying to reduce so-called symptoms or alleviate problems.

Change occurs by using methods that enable the patient to attain a level of strong feeling, to appreciate the accessed inner experiencing, to be the inner experiencing in the context of earlier scenes, and to be and behave as this inner experiencing in the context of imminent future scenes.

It is here that I converge with the other respondents, because I use many of their methods (techniques, procedures) in one or more of the four steps.

George Strieker

I agree with Mahrer as to the desirability of following the patient's lead and amplifying those areas that are most salient to the patient. I would arrive at some clinical inferences and use these as a guide to my understanding, but I, too, would try not to impose these on the patient.

The relationship described by Mahrer is a highly empathic one, and I agree with the desirability of achieving this. My purpose in seeking to establish such an empathic alliance would be to heal past wounds as well as to have the here-and-now impact that Mahrer describes. However, I do not agree with some of the technical approaches taken by Mahrer. The relationship that he seems to be establishing is not simply empathic; he places demands on the patient for certain kinds of material, and that material

is filtered through the therapist's unique set of responses. This use of countertransference (certainly not the theoretical formulation that Mahrer would adopt) requires much more attention to what the therapist is contributing than is described, and it requires a less certain and blanket assumption that it will be helpful to the patient.

There are a number of techniques described by Mahrer that I find problematic with this specific patient:

1. Asking the patient to close his eyes before you know him very well can be counterproductive. With Michael, fearful of authority as he is, and possibly concerned with homosexual attack, I think this approach would be a grave error, and possibly one that could shatter the potential for an alliance.

2. Demanding the expression of frightening feelings, again before trust has been established, may tend to confirm Michael's fear that he will be assaulted.

3. The sadistic fantasies seem correctly perceived as sexual- ized, but their encouragement might not lead to the response from Michael that is hypothesized. He might amplify them rather than exult in them, and surely he would be terrified by them (or perhaps it is I who would be terrified, but that is why I would like the patient to be the source of the feelings).

I agree with Powell's formulation of the case. I, too, would want the

additional information that he would seek, along with a number of other things. However, I would assume that I would learn them all in due course. I do not do a thorough intake interview during the first session, but I ask for amplification of issues as the patient raises them. Occasionally I comment about issues that the patient has not mentioned. Both Powell's behavioral and dynamic interventions are as I would approach them, but I would order them differently. I would not begin with techniques directed toward individual symptoms, but would prefer to develop a more thorough understanding of the patient first. If, in the course of the exploration of general patterns, any symptoms remained troublesome and recalcitrant, I would consider the use of targeted behavioral interventions.

My choosing whether or not to keep Michael focused on the presenting issues, as Powell does, would depend on the time span projected for the treatment. Powell suggests long-term treatment. I agree, and if this were to be undertaken, I would be less concerned with focus than I would be for short-term treatment. Finally, I definitely would begin with individual therapy and would also consider the introduction of group therapy at a later point in treatment.

I agree with Rice's initial emphasis on empathic responding. I also agree with her observation that some of the more understated material may prove to be more important than the more flamboyant fantasies. The purpose of

these fantasies may be to test the therapist and his or her capacity to accept, tolerate, and like the patient. I also feel that individual therapy is the better choice for Michael and that the relationship would be crucial regardless of the approach taken by the therapist.

I share Rice's feeling that Michael is appealing and that I could trust and respect him. More to the point, could he trust and respect me? There will be many tests, I will need to pass most of them, and he will have to learn to tolerate those that I fail.

Douglas H. Powell

What is so striking to me from reading the discussion by Mahrer, Strieker, and Rice is how many ways there are to conceptualize a complex case such as this and how many ways there are to do right by Michael. In my view, significant benefit would accrue to him from working with any of these individuals. Each brings to the treatment process ingredients associated with positive outcomes: compassion and respect for the client; an inclination to commitment, support, and empathy; a disinclination to go for the quick fix; the value of sharing poorly understood, conflicting, and inchoate feelings; and nurturing the hope in such an alliance.

As for points of convergence with my fellow panelists, I agree with the

presumption that Michael's symptoms are related to his inadequate understanding of his inner experience. In spite of his psychological sophistication, intelligence, and previous therapy, he remains a mystery to himself. As Rice points out, his insights have a prepackaged quality. Strieker notes his avoidance defensive mechanisms, which leave him in a constant state of anxiety. Mahrer assumes from the beginning that Michael's initial thoughts and affects will give way to other feelings and to so-called inner experiencing closer to the center of Michael's conflicts.

We also are in agreement on three other major points. The first is the pivotal role of Michael's conflicts about aggressive instincts, which should be a central focus of treatment. The second is the agreement that group therapy is not indicated in the early going, or perhaps ever. Third, we concur that it is crucial for Michael to achieve a clear understanding of his experiential life, his past conflicts, the reality distortions arising out of defenses against anxiety, and his tendency to engage in self-handicapping endeavors. The growth of his capacity for self-understanding will be a necessary condition for maintaining the improvement that should occur in any of the therapies.

I now turn to areas of contention. Nearly seven years have passed since the Society for the Exploration of Psychotherapy Integration (SEPI) was founded, marking the "official" beginning of the integrative therapy movement. I am struck by how little impact this thinking apparently has had

on my three prominent and skilled colleagues, whom I both respect and like personally. Reading their accounts of how they would imagine helping Michael, I have the impression that they would plan to follow a single theoretical perspective— experiential, psychodynamic, or Rogerian— unadulterated by the addition of other ways of conceptualizing the problem or other avenues of intervention. I found myself reminded of the *Four Psychotherapies* (Hersher, 1970) in which leading practitioners of two decades ago described how they would treat the same patient. It distresses me to think that so little has changed in twenty years.

A major point of divergence from my colleagues in the proposed treatment of Michael would be my conviction that multiple forms of therapy would yield more positive and enduring results than would a unitary approach. Moreover, there may be potentiating value in particular pairings or sequences of interventions (Millon, 1988; Powell, 1988). My choice of focusing on the cold hands and the breathing problems is an example and is at odds with the other clinicians. My experience, however, has been that this approach provides at least four benefits: (1) possible symptom reduction, (2) a greater sense of agency, (3) alleviating the distress of symptoms so that their function might be explored, and (4) the possibility of spontaneous insights into the nature of repressed conflicts surrounding the symptoms. Any of these effects could lead naturally into psychodynamic exploration of the

origins of the difficulties.

Another major point of divergence is the likelihood of my being more directive in terms of suggesting things Michael could do outside the therapy to enhance his development. These might include encouraging him to develop his playful side or join a growth group. The dangers in this directiveness need to be appreciated, especially in terms of his conflicts with authority and passive-aggressive style. Should these conflicts emerge, they could be explored by insight-oriented therapy.

Laura N. Rice

I fully agree with Mahrer that the useful material would emerge if one encouraged and really heard Michael's own experiencing. The basic difference between us is in the working relationship. I would want to establish and maintain a relationship in which I was not the instructor and in which I would never totally merge myself with and speak from Michael's emotions. I would try to respond with evocative and truly empathic reflections, but I would consider it very important to maintain my own identity and the quality of the real relationship throughout.

Regarding George Strieker, I think I would feel very comfortable with many aspects of his approach, such as the importance of building a safe and

trusting relationship. Clearly, the quality of this relationship is central for him. For instance, he states that he would not try to encourage Michael to express his anger; but when it is expressed, Michael's recognition that Strieker is not put off or disturbed by the anger would be curative in itself.

On the other hand, I would not want to follow Stricker's emphasis on forming and testing a series of hypotheses. Clearly, with a background knowledge concerning personality and psychopathology, one could not help having some ideas about the effects of Michael's developmental background and the conflicts with which he is struggling. I would not focus my energy and attention on these ideas, however. I would try to hear Michael as freshly as possible and to be aware of the feelings and other inner experiences that are salient for him at the moment. I would try, by means of empathic, open-ended reflections, to facilitate his expression and exploration of these inner experiences. I have often found that my expectations and assumptions may be in the right general area but that the actual feelings and perceptions that can emerge in a really good exploration are idiosyncratic and have a unique flavor. If I can really hear and respond to this special quality, it will turn out to be the most important part of the therapy. My assumption is that if Michael can make his own discoveries, and if I can hear and respect them, he will become more and more able to use his own organismic experience as a guide to satisfying relationships and functioning in the world.

I share some of Powell's enthusiasm for an integrated therapy, but I feel strongly that the combination of approaches used must be internally consistent with one another, and especially with the nature of the basic therapeutic relationship. This consistency is one of the challenges for psychotherapy integration.

I would probably not use behavioral techniques early in therapy because my primary goal would be to establish a process of experiential search in which Michael was the leader of the search. At some point, however, I might suggest a behavioral self-help strategy as something that he might find useful. If he seemed interested, I would help him to design such a program, but I would not push it.

I would not try to have Michael recognize the so-called "historical origins" of his anger, although they might emerge spontaneously. I would see it as more important that he make his own discovery of the unique quality of his own anger. It was interesting that Powell said he would listen for Michael's "spontaneous recognition" of relationships between intense feelings and the physical symptoms. Here again the issue in combining approaches seems to me to be whether one can contribute therapist-generated causal connections without losing the impact of the discoveries emerging from experiential search.

Authors

Alvin R. Mahrer, Ph.D., is professor in the School of Psychology, University of Ottawa. Author or editor of ten books and numerous articles, his primary work is aimed toward the development of the practice and theory of experiential psychotherapy, and his secondary work is aimed at discovering how psychotherapy works.

George Stricker, Ph.D., is professor of psychology and dean of the Derner Institute of Advanced Psychological Studies, Adelphi University. A diplomate in clinical psychology, he maintains a part-time independent practice in clinical psychology. He is past president of both the Society for Personality Assessment and the National Council of Schools of Professional Psychology. Stricker's most recent book is the Handbook of quality assurance in mental health (1988, with A. Rodriguez).

Douglas H. Powell, Ed.D., ABPP, is a psychologist and lecturer at Harvard University. He coordinates the Behavior Therapy Program at the Harvard University Health Services. In addition, he is president of Powell Associates, a group providing psychological consulting to individuals, schools, and corporations. He is author of Teenagers: When to worry and what to do (1986) and numerous articles on integrative psychotherapy.

Laura N. Rice, Ph.D., is professor emeritus in psychology at York University in Toronto and is currently a consultant to the University Counseling and Development Center. She is coeditor of Innovations in client-centered therapy (1974, with D. A. Wexler) and Patterns of change: Intensive analysis of psychotherapy process (1984, with L. S. Greenberg).